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ABSTRACT

Proceedings from the first in a yearly series of conferences on dental hygiene education sponsored by the American Dental Hygienists' Association are presented. Three sessions are as follows: (1) "Society at Large: Economics, Cultural Trends, Work Trends, Demographics, and Technology" (Felix Kaufmann); (2) "The Health Care System: Changes and Implications" (Barbara Kramer); and (3) Higher Education and the Health Professions" (Carol Lindeman). An evaluation of the workshop is provided. Twelve appendices are: agenda; goals; steering committee; facilitators; participants (institutional representatives); participants (constituent representatives); representation maps; bibliography; nominal process; letters; articles; and evaluation summary. (SM)

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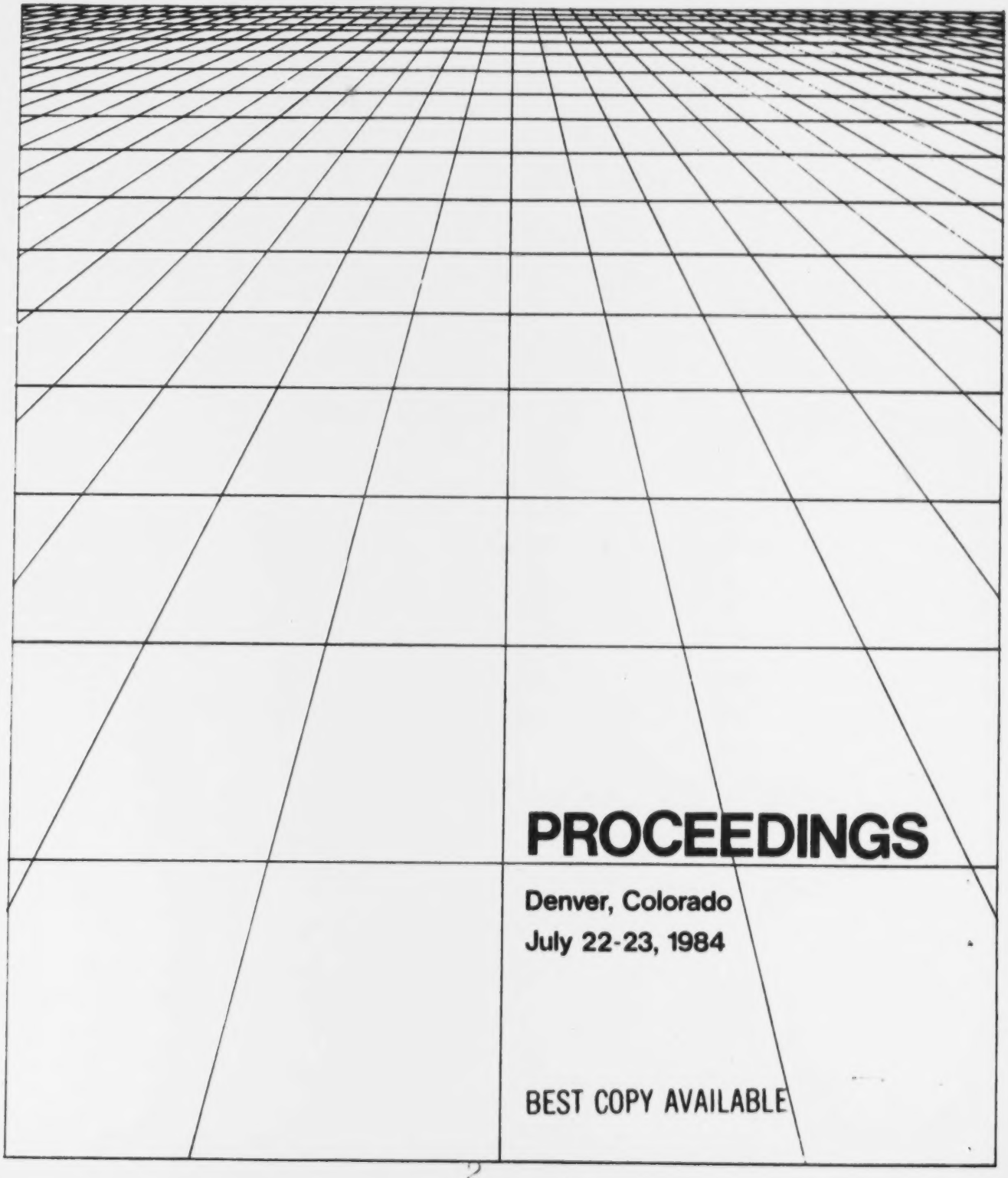

PROCEEDINGS

Denver, Colorado

July 22-23, 1984

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ACKNOWLEDGEMENTS

This conference was made possible through the generous support of the American Dental Hygienists' Association.

Appreciation is extended to each and every Workshop participant for the commitment and expertise which they provided to this Workshop.

The proceedings have been prepared by the Steering Committee and ADHA Professional Development staff based on the papers presented, the discussion at the general sessions and other documentation.

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INTRODUCTION

Many segments of ADHA have felt the need to define a direction for the future of the dental hygiene profession. In 1982, the ADHA implemented a planning process and developed a mission statement and long range goals. In 1983, in keeping with the futuristic planning, dental hygiene program directors attending the National Dental Hygiene Directors Conference (NDHDC) discussed the need for dental hygiene educators and practitioners to work as a cohesive unit in defining the future characteristics of dental hygiene education and practice.

The Directors attending the 1983 Conference (NDHDC) agreed that if national consensus on the goals for and structure of dental hygiene education was not reached, the educational system would be undermined by economic and political pressures and internal counterforces. They also recognized that the establishment of educational goals and structure is particularly critical to practitioners and that if dental hygiene is not established as a distinct and essential resource in health promotion and health care, it will continue to be the buffer in accommodating fluctuations in dentists' "busyness".

Participants of the Directors Conference took action in the form of a proposal for a series of workshops to gain national consensus within the dental hygiene community. The proposal, which was accepted unanimously, outlined three workshops along with goals for each as follows:

Workshop I in 1984:
Goal: Address philosophy and general goals for Dental Hygiene education in the context of projected public need for dental hygiene care.

Workshop II in 1985:
Goal: Define the academic and clinical preparation required for dental hygiene to meet these needs.

Workshop III in 1986:
Goal: Define the educational systems and resources to meet the goals, and strategies for attaining those goals.

The proposal, along with a list of names for consideration as a Steering Committee to plan the workshops, was submitted to the ADHA. The Board of Trustees and the House of Delegates of ADHA adopted the proposal and a six-member Steering Committee was appointed from the names submitted by the NDHDC.

The Steering Committee met in December, 1983 to begin development for Workshop I. The Committee determined the Workshop format and developed a bibliography of resources for Workshop participants that would address the health care issues, prevention, current research and strategies for

change. The bibliography is included in the appendix. The goals established for Workshop I were:

1. Develop consensus on the implications of relevant social, educational, political and professional factors for future dental hygiene practice.

2. Forecast the future role of Dental Hygiene in health promotion and health care in the context of social, educational, political and professional factors.

3. Develop consensus on dental hygiene education philosophy and goals in the context of the projected role of Dental Hygiene in health promotion and health care.

Realizing that the issues facing Dental Hygiene are common to all health care professionals and to society at large, it was important to establish a broad base for the participants. Experts were sought out to address the issues of health care delivery and societal trends; cultural, economic, demographic, technical and political trends; and finally, issues and trends in higher education and the health professions. Presentations were prepared with consideration given to the suggested bibliography and the anticipated dental hygiene community that was invited to attend.

Providing an opportunity for each participant to express opinions and influence consensus development was a primary consideration in selecting the workshop format. The process developed to reach this was critical. It was expected that a great deal of discussion would be generated as the conference progressed. To that end, it was important to establish a forum where all participants could contribute their expertise, could bring their discussions to the total group and could facilitate consensus development by the participants as a body. To aid in this process, group facilitators were selected from the registered participants to represent both the educational and the practice community. The nominal process was chosen and is outlined in the Appendix.

The Steering Committee considered that it was appropriate and essential that Dental Hygiene define its future through deliberations by their constituencies. They determined that it was important to examine its future without the influence of outside organizations or agencies whose representatives would be obliged to speak from the policy base of the group they represented. For these reasons it was decided that the Workshop attendance be by invitation and that every effort be made to assure representation from the entire dental hygiene community. Therefore, invitations for representatives were extended to every dental hygiene educational program, every ADHA Constituent and relevant ADHA Committees and Councils.

The issues addressed were complex and multi-faceted, and the participants represented diverse groups within dental hygiene with equally diverse concepts concerning the future of Dental Hygiene. This

first Workshop brought together individuals with the intellectual resources and the commitment to identify ways to move the profession of Dental Hygiene forward, and with the knowledge that the strength necessary to be successful would come from national consensus on the goals and methods to do so.

The workshop program was divided into three sections. Each section was designed to focus on one of the three workshop goals. The relationship of societal trends to the future of dental hygiene was considered initially. A potential effect of changes of health care policy and health care delivery on the future was deliberated in the second section. Finally, deliberations centered on issues which relate to recognition as a health profession and health profession education.

First Session of Workshop I

As the title of the first presentation during Workshop I implies, the focus of Dr. Felix Kaufmann's address provided a global perspective of socio-economic, political and cultural changes occurring in society today and illustrated how these changes affect change in existing social institutions. Dr. Kaufmann's presentation follows:

SOCIETY AT LARGE: ECONOMICS, CULTURAL TRENDS, WORK TRENDS, DEMOGRAPHICS AND TECHNOLOGY

Felix Kaufmann, President, Science for Business, Inc.
Ypsilanti, Michigan

"In case you are tempted to smile at such an ambitious title, please consider that my function is not unlike that of Quince, the carpenter, who clumsily introduces the play-within-a-play in Shakespeare's Midsummer-Night's Dream with the grandiloquent words:

> The actors are at hand and by their show
> You shall know all that you are like to know

If my title seems to be making a similarly unfulfillable promise, please remember that, like Peter Quince, I stand here just to provide an introduction and setting for what follows; in this case two very knowledgeable, experienced and distinguished speakers who will cover the real substance of this Education Workshop: education and health care.

Drastic changes will have to take place and will take place in those two fields; but the reasons for these changes can be understood better when we consider the society at large. Let us start with the demographics. As you all know, everywhere in the world more male babies are born than female, and up to the age of 30, males outnumber females in the U.S. and in most other countries.

Through most of human history there used to be altogether more men than women, despite the fact that more men were killed on the job and in war. In this country that held true until World War II. Since then we have had a female majority in this country and the margin is increasing.

Right now we have about six million more women than men. And the disparity is even greater above the voting age of 18. Very gradually, that is going to make a difference to the relative influence of women in our society.

Another great demographic change that is taking place is the aging of our society. This year, for the first time in our history, the median age of our population is 31. That means half of the population is 31 or over. And the median age of the voting population, of course, is much higher still. More than half of those entitled to vote are in their forties and over. Let me tell you a secret about us people over 40.

One of my hobbies is ancient literature: Latin, Greek, Hebrew, Aramaic, Sanskrit, Akkadian, Egyptian, Summerian--the older the better. And one thing that has struck me for a long time about the literature of the last 6,000 years is that in all cultures people continually complain about the deterioration of human behavior and about the decline of what we now call 'the quality of life'. Some of the writers are from Asia, some from Africa and some from Europe--there is only one thing they have in common: they are all over 40 years old.

Now if most of these complainers were objectively right, the world would have to be a far worse place than it was 6,000 years ago; in fact it must have grown very steadily worse all the time, so that at any given time human behavior must have been considerably worse than a thousand years earlier and the world a much worse place to live in.

And that simply is not the case. Quite the contrary! The ordinary people living in Europe's big cities today have comforts that the aristocracy and royalty of 984 AD would have envied. They do not constantly harbor lice in their hair, fleas in their clothes and bedbugs in their beds. They do not have to shiver with cold throughout the winter, ever near the fire in the middle of a room filled with acrid woodsmoke. If you lived in the countryside in those days, it was even worse. From the medieval fairy tales and songs collected by the brothers Grimm, it is quite clear that a young woman walking from one village to another was as likely to be raped as not if she encountered one or several men; and that a man who stayed at a country inn overnight stood a good chance of being murdered if the landlord or other guests had reason to believe that he had more than the ordinary travel money on him.

So human behavior, too, much as we complain about it today, is not noticeably worse than it used to be. In the United States today, the chance of being punished after committing a horrible crime is not much better and not much worse than in the Middle Ages. The main difference is that you were even less likely to be caught then. But once you are apprehended today, your chance of getting severely punished is low even when you are guilty; back then your chance of escaping the death penalty was low, even when you were completely innocent. Take your pick; but I see no evidence that human behavior is any worse today, and by almost any measurement the quality of life today is higher than it has ever been.

Even if the 6,000-year-old chorus of complaints does not teach us anything about the world, it does teach us something about people over 40. They tend to be nostalgic about the world of their youth and they tend to be skeptical about change. We have a word for those tendencies: conservatism. We would expect the voters of today to be more conservative than those younger ones who elected Lyndon Johnson in a landslide 20 years ago. And we may expect voters to be even more conservative in the next decade, when the baby boom generation enters its forties.

If you find that hard to believe, consider this. The Republican party delegates turned down Ronald Reagan as their presidential candidate in 1972 and again in 1976 because they considered him too conservative. In 1980 they did pick him and later that year the voters, of whom a plurality considered themselves Democrats, endorsed that choice.

After having swung very sharply leftward during the New Deal era of Franklin Delano Roosevelt, Americans are definitively turning more conservative again. Not extremely conservative , by the way. Ronald Reagan sees himself as a Roosevelt New Dealer and he has not really gone very far to the right of that. The country went so far left as to make him look very right wing. His sympathies may actually lie further right; but he is a pragmatist and he annoyed most of his extreme right-wing supporters by not doing very much for them when it was clear that the country was in no mood to move that far.

We have seen a similar shuttling between left and right in the European democracies, also with the same disinclination to go too far in either direction. Indeed, it is sometimes difficult to guess who is in charge, if all one has to go by are the actions of the government. While in power, European socialists like President Mitterand, Chancellor Schmidt, and prime ministers Craxi and Gonzalez have all been far more middle-of-the-road than socialist. Here, similarly, we can probably expect further administrations which call themselves conservative, but which actually are, and behave as, middle-of-the-roaders.

Another interesting demographic trend should be mentioned: the number of Hispanics in the U.S. is increasing faster than that of any other ethnic group. This occurs in three ways:

1. By legal immigration from Puerto Rico, Mexico and some other Latin American countries.

2. By illegal immigration from Mexico and other Latin American countries.

3. By what is jokingly called 'internal immigration', a very high reproduction rate among all Hispanics here, whether they are citizens, legal or illegal immigrants.

In each instance we are dealing with millions of new arrivals each year. This has not yet substantially affected the U.S. at the national level; but the strong impact is already unmistakable in New York City and some Texas and southern California towns which have become, in effect,

bilingual, and large sections of Miami and Los Angeles, which have become totally Hispanic.

By the 1990s, Hispanics will be the single largest ethnic group in the huge and populous states of California and Texas, with an absolute majority in many counties, which by itself will make them a political force to be reckoned with. The three states, California, Texas and Florida, currently account for 40% of the total population increase of the whole United States. And that increase is largely due to Hispanics.

In addition, Hispanics will overtake blacks as the largest 'minority' group in the country and will undoubtedly have to be wooed by candidates for national office, even outside the Southwest. The huge number of Spanish-speaking children, many of them not very proficient in English, will create further problems for an already grossly inadequate school system.

Yet this is minor compared to quite another challenge facing the school system--preparing our children for the information age in which they will have to live and work. In all developed countries, the profitability of traditional labor-intensive factories is decreasing. Many have already ceased: shoe factories, many textile mills, steel mills and electronic assembly plants (such as TV sets). Others, like autos in the U.S., are being kept artificially alive by worker give-backs (which will not continue) and by import barriers such as "voluntary" quotas and domestic-content legislation.

Such factories, where most of the work force is uneducated and untrained, but where they have to be highly paid, are unsuitable and unprofitable in developed countries. In contrast, they are ideal for developing countries which are glad to put up with the pollution and other drawbacks as long as they receive a transfer of technology, even outdated technology, employment for their masses, and the ability to produce exportable goods to pay for the many imports needed.

The present owners of traditional labor-intensive factories in developed countries have very limited choices because it is not financially justifiable to build new factories of the same kind to replace their present aging facilities. In no 'old' industry is it possible to get a high enough return on the investment to pay amortization and interest on the construction and machinery.

These owners can let their old factories, which often are already amortized and therefore still profitable, run on until new recruits are no longer available to replace the older workers who retire from the work force every year. That is already happening in many industries, even at double-digit pay per hour for new, untrained (and largely illiterate and innumerate) entrants.

Another possibility is to automate very heavily, largely eliminating the need for unskilled labor. What factories remain in developed countries will be practically or totally workerless. Japan has already gone some way along that road, and a few successful individual companies in the United States (even a couple of steel mills) and Europe are doing the

same; but it is very unpopular, for obvious reasons, with the government and the unions.

The remaining possibility is to earn money by selling know-how and old machinery to Second and Third World countries eager to acquire a manufacturing base. Being short of hard currency, those countries will probably prefer to pay with the manufactured goods themselves, which precludes immediate payment; on the other hand, the goods manufactured abroad are likely to be a good deal cheaper, so that both sides profit. The losers are those industrial workers in the developed countries, who are unwilling or unable either to accept less than the very high wages they are accustomed to or be retrained in new occupations requiring greater literacy and numeracy.

The industries which are and will be profitable in the developed world are in many respects different from the old smokestack industries on which prosperity was based until recently. They are less of a threat to the environment and more interesting to work in, by and large; but they do demand greater skills, not only greater than those which used to be expected from factory workers, but greater than the vast majority of American high school students have acquired by the time they graduate.

Japan's enormous economic successes compared to most other First World countries are due primarily to four factors:

1. Greater foresight of management in picking the industries of the future.

2. Greater willingness of management, workers and government to abandon industries without a future before they actually go bankrupt and to switch to more promising ones.

3. Much better elementary and secondary education (despite the need to learn three different script systems, illiteracy in Japan is practically unknown, while we have about 25% illiterates and even more functional illiterates).

4. Greater consciousness and quality consciousness of workers and management.

The industries which are going to be profitable in the last decade and a half of this century will be:

-Biotechnology, medicine, health care and health care delivery.
-Energy transformation, telecommunications, sensors, switches.
-Artificial intelligence, information processing.
-New materials: alloys, synthetics, quasi-living mater.
-Food production: radically new crop species, aquaculture.
-Space vehicles and supersatellites.
-Communications, machine-assisted teaching and learning.

Many of these fields will overlap even more then they do today. But there will be spectacular progress on many fronts. The main limiting factor is the unwillingness of developed nations to let go of the ailing technologies and concentrate on the promising ones. Even so, the

current weekly breakthroughs in cancer and virus research, coupled with the constantly growing understanding of immunity process, will allow the eradication of all acute and most degenerative diseases before the end of the century.

Foods of high nutritive value will become so cheap that even the poorest will have much better nutrition than today, when hundreds of millions are literally starving. Education, especially self-education, will become easier and more interesting. And not a moment too soon! For the present system of elementary education is not adequate to produce the generation of knowledge workers indispensable for the world of tomorrow.

The greater availability of education and information will make also for much more sophisticated health care consumers. There will be much greater emphasis on disease prevention and conservation of health than on curing conditions that have arisen--the main preoccupation of most health professionals today, I am afraid, except the profession represented here. But of that you will hear more from the distinguished speakers who will succeed me on this podium."

A brief question and answer period followed Dr. Kaufmann's presentation. Participants then reported to their discussion groups with the charge to: (1) Identify changing societal trends that will influence the future direction of dental hygiene and (2) develop a consensus opinion of those societal factors that were viewed as most important. When the general session reconvened, each facilitator presented the group report. Issues deemed most important by the assembly at the first general session were:

1. Population Changes

Participants were in agreement that present and projected changes in population demographics, particularly those related to age and sex, would significantly influence the future of dental hygiene. For example, general and oral health conditions of an aging population which is increasing at a greater rate than other segments of the population, will require dental hygienists to develop more realistic standards for dental practice. This will include development of comprehensive definitions of rational prevention treatments. In addition dental hygienists will be required to adapt the mode of delivery of preventive services to a variety of practice sites.

The rapid growth of racial and ethnic minorities, especially Spanish speaking and Asian Americans, was seen as another challenge affecting future dental hygiene practice. If in the 1990's, the United States will be a bilingual nation, (as some prognosticators believe), dental hygienists will need to communicate in both English and Spanish. In order to be effective communicators and change agents, dental hygienists will need to use preventive intervention skills relevant to the culturally diverse populations that will exist in this country. Without comprehensive knowledge and understanding of the attitudes and cultural values of these populations, prescribed preventive dental hygiene interventions may not be compatible with cultural characteristics of the given population.

The discussion of population distribution focused on the rising proportion of females. It was felt that this trend may positively affect the number of people seeking dental care, since traditionally more women than men have sought dental services.

2. Changing Roles of Women

The changing role of women in today's society, specifically their quest for social, political and economic equality, was seen as an important societal change. The affect of this change could have both positive and negative influences on the future professional advancement of dental hygiene. The women's movement could be advantageous in promoting dental hygiene as a career and in seeking increased professional self-reliance. However, as women move toward greater independence and seek increased decision-making responsibilities they may move away from traditional female occupations or select careers in one of the established professions.

3. Changing Technology

Movement away from an industrial to an informational based society was another factor participants identified as having significant implications. Computer technology will permeate all aspects of the work world. Similarly, alternatives will occur in traditional health fields as well. Dental hygiene must be prepared to think and plan futuristically to accommodate informational technology systems, the implications of which to date are unknown.

4. Changing Consumer Expectations

Participants identified increased consumer activism as an issue that will have significant impact on the future of dental hygiene. Examples such as more sophisticated levels of knowledge and increased political activism were given as evidence of this growing consumerism trend. Consumer interest in containment of medical costs and accessibility of care were seen as issues that could provide impetus for the reorganization of dental care systems. A corollary to this would be the removal of arbitrary barriers which presently restrict dental hygienists from providing maximum primary preventive and therapeutic dental hygiene care.

Another issue related to changing consumer behavior that was identified as having a potential and significant impact on the future of dental hygiene was the growing public interest in the concept of wellness, self care and determination for one's health status. This emerging public attitude could provide direction for expanding the boundaries of dental hygiene, since historically, unlike the development of other health professions, dental hygiene has focused on the preventive rather than the curative aspects of disease.

5. Growing Public Interest in Cost Containment

Public concern for cost containment in all aspects of the national economy was viewed as an important issue for consideration. National

attention given to spiraling health care costs was seen as an unresolved problem that could be instrumental in affecting major change in dental hygiene practice.

6. Changing Health Care Delivery

Anticipated change in health care delivery was also viewed as a positive factor facilitating movement of dental hygienists into alternative practice sites. These alternative settings would include working with special population groups such as the homebound, nursing home residents and institutionalized persons. A complimentary and supportive issue which could provide impetus for maximum utilization of dental hygienists in alternative practice sites was seen in the advancement of public health measures for the prevention and control of oral disease. Recognized changes in oral disease priorities and the need to develop cost effective programs provide further rationale to support recognition of the dental hygienist as the logical primary provider of preventive dental services.

7. Changing Societal Values

In addition to identifying changes in social institutions and in social needs, participants discussed changes occurring in the American value system and the implications of these changes on the future of dental hygiene. It was felt that a higher value or greater social consciousness has developed in society as evidenced by the increased public attention given to special populations such as the indigent minorities, migrant workers, the elderly and the handicapped. Other examples of this increased recognition of the need for social justice and equity were seen in public expressions of concern related to domestic policies. This is illustrated in our society today by the concern given to family violence, exploitation of children, women, the aged, and the institutionalized, as well as by environmental issues such as air and water pollution and the unwarranted and wasteful use of natural resources.

Values associated with domestic issues extend into changing values related to the work ethic and work setting. It was in this area that the focus of discussion centered. Personal feelings of worth associated with the work place, that is, being respected for one's ability, making independent decisions based on the knowledge and skills possessed and assuming responsibility for one's actions were examples cited. Considerations such as these were viewed as key factors in the future ability of dental hygiene to continue recruitment of highly qualified applicants and retention of dental hygienists who view dental hygiene as a satisfying lifetime career.

Second Session of Workshop I

In the second presentation during Workshop I, Dr. Barbara Kramer focused on the changes occurring in the health care system and the implications of these changes. Dr. Kramer's presentation follows:

THE HEALTH CARE SYSTEM: CHANGES AND IMPLICATIONS

**Barbara B. Kramer, PhD, Chief, State Health Planning Section,
Department of Human Resources
Raleigh, North Carolina**

"We are in the process of a major revolution in the delivery of health care in the United States. This may sound somewhat dramatic, but I believe that you will be convinced that we are heading toward some major changes in the health care system that will have substantial impact on the system as we know it today.

Historical Background

Let's begin by taking a look at some historical data about the health care system and how it has changed. From the period of 1880 to 1910, a 30-year time period, the health care system evolved from a nonsystem--there were only 175 hospitals, no nursing schools, no licensed physicians, and funding was purely through philanthropic contributions--to the system we are familiar with today. By 1910 there were 6,000 hospitals; one out of every four hospitals had a school of nursing; and all physicians had to be licensed and have some practical hospital experience before actual practice, and the private patients paid for their health care services. Table I shows these change over a 30-year period.

Table I: Historical Changes in the Health Care Delivery System, 1880-1910

Hospitals	
1880	175 Hospitals
1910	6,000 Hospitals
Nursing Schools	
1880	No Nursing Schools
1910	One out of every 4 hospitals had a School of Nursing
Physicians	
1880	No licensed physicians
1910	Physicians must be licensed and have hospital experience before practice
Board of Trustees	
1880	Board members controlled hospital admissions and discharges
1910	Physicians controlled hospital admissions and discharges
Financing	
1880	Philanthropy
1910	Private Patient

As you can see, the health care delivery system went through major changes in a short 30-year time period. I would propose to you that during the next 30 years, from 1980 to the year 2010, we will see changes that will be at least of the magnitude that occurred in the late 1800s. As of 1980 there were approximately 6,200 acute care hospitals in the United States and by the year 2010, that number will be greatly reduced. I am not willing to suggest that we will go all the way back to 175 hospitals, but I do believe that we will see a tremendous shrinkage and community hospitals, as we know them today, will not be recognizable.

Some of the professional associations have already made projections about changes in the numbers of nurses and physicians. As of 1980, we had approximately 117,300 RNs and LPNs, and it is projected that this number will be reduced to approximately 82,400 by the year 2000.

Another major change relates to the composition of hospital boards and financing mechanisms for hospitals. In 1980, there were 5,499 public not-for-profit hospitals. By the year 2010, it is anticipated that there will be a major shift to the for-profit, large chains. Also, there will be a significant overall reduction in the total number of boards of trustees in hospitals.

While major changes may not appear to be dramatic on the surface, there are other changes going on at the same time that will cause the health care system to look very different by the year 2000 from the way it does today.

Where Health Care is Now Delivered

In order to have an appreciation of how some of these changes will affect our system, it is important to have a picture of where health care is being delivered currently and how delivery settings are already beginning to change. Table II provides a listing of the various locations in which health care services are now being delivered. In the past, it has been most common to receive various health care services in the physician's office or dental office.

As you are probably aware, the single practitioner model is becoming an extinct entity. It is much more typical to find health care practitioners in group settings, both groups of similar specialties as well as groups of multiple specialties. It is also common to find health care providers located in medical office buildings, even if they don't practice as a formal group.

More recently, we are seeing the development of special community facilities such as adult day-care centers, community mental health centers and recreation centers. All of these types of facilities are becoming places where health care services can be provided to larger numbers of individuals without requiring the transportation of individuals to a practitioner's office. In a similar light, health care services are offered through the business or commercial model, i.e., through chain stores and shopping malls.

Table II: Where Health Care Is Delivered
(Examples--Not All Inclusive)

- Physician Office/Dental Office--Single Specialty
- Group Practice Setting--Multiple Specialities
- Special Community Facilities--Adult Day Care Centers, Community Medical Health Centers, Recreation Centers
- Commercial Facilities--Chain Stores, Shopping Malls
- Institutions--Designed for Health Care Delivery
  - Acute Care Hospitals
  - Specialty Hospital (Orthopedic, TB)
  - Nursing Homes
  - Mental Health Facilities
  - Rehabilitation Facilities
  - Ambulatory Surgery Facilities
  - Birthing Centers
  - Alcohol/Drug Facilities
  - Psychiatric Hospitals
- Residential Treatment Facilities
  - Domiciliary Homes
  - Group Care Homes
  - Homes for Developmentally Disabled
  - Alcohol/Drug Treatment Residences
- At Home
  - Hospice Services
  - Home Health Services
  - Self-Care

We also have a system of institutions that is specifically designed to provide various types of health care services. These institutions specialize in such things as acute care and medical specialities such as orthopedic, ear, nose and throat. Then there are institutions such as nursing homes, mental health facilities, rehabilitation facilities, ambulatory surgery facilities, birthing centers, alcohol/drug facilities and psychiatric hospitals.

The next type of facility that has been developed is the residential treatment facility. Included here are: domiciliary homes, group care homes, homes for the developmentally disabled and alcohol/drug treatment residences.

Finally, we are beginning to see more and more health-care services delivered in home settings. Specifically, there has been a movement to provide services for terminally ill patients at home through the hospice program. A wide variety of health services can be provided in the home rather than requiring a person to come to an institutional, community or

practice setting. Finally, we are seeing more and more care delivered by individuals themselves in home settings.

Changing Emphasis on Where Health Care is Delivered

Now that we have an idea of all of the different locations where health care is delivered, we should think about how the emphasis is changing on where care is delivered. I have outlined five major propositions regarding the changing emphasis on where health care is delivered.

1. Less health care will be delivered in institutions, especially hospitals:
   -Small, primary care hospitals will close or change focus to outpatient services.
   -Larger hospitals will become centers of high technology; there will be fewer hospitals and patients will be transported greater distances.
2. More health care will be delivered on an outpatient basis in specialized centers:
   -Ambulatory surgery centers
   -Birthing centers
   -Plastic surgery centers
   -Eye centers
   -Laboratory testing centers
   -Rehabilitation centers
3. More health care will be delivered through commercial enterprises:
   -Shopping malls
   -Businesses
   -Department stores
4. More care will be delivered through community services and home-based services and through the schools:
   -Health services--physical and occupational therapy
   -Preventive services and education.
5. More health care will be self- or family-administered:
   -Taking blood pressure
   -Blood tests
   -Pregnancy tests
   -Tests for cancers
   -Home dialysis

New Technology

Equally significant, or perhaps even more significant, are the changes that will take place in how health care is actually delivered. We have talked about where health care is delivered, but the changes in new technologies that will make it possible to self-administer tests for cancers will have a major impact on both how and where health care is delivered.

Let me review a couple of major technology breakthroughs that already are causing change in how health care is being delivered. One example is a new piece of equipment called a magnetic resonance imaging device (MRI). This is a major piece of new equipment that costs several million dollars and is intended to replace the traditional x-ray. One

of the major breakthroughs with the use of this type of magnetic imaging device is its ability to detect changes in human internal systems--such as blood and arteries. This will allow many diseases to be detected at a much earlier stage. The implication of such a change would be earlier detection, earlier treatment, and perhaps a limited need for hospitalization.

Another example of new technology is a piece of equipment called a Lithotriptor. This device is commonly referred to as a 'kidney stone crusher'. As described to me, an individual is submerged in water and through the use of this machine, the kidney stones are dissolved. It does not require any invasive surgery and will be utilized, according to some, on an outpatient basis. Another area where major research is going on is in the area of transplantation--the most recent is the brain.

And, finally, one other example which is a little bit closer to the dental area is the use of various types of sealants. With new technology, it may even be conceivable that dental caries can be totally eliminated. You probably should also be thinking about what impact the magnetic resonance imaging technology may have on the traditional use of x-rays in dental practices.

These are only a few examples of some of the new types of technology already being utilized which are making significant changes in how health care is and can be delivered.

Another area where there is tremendous growth and potential for application to health care delivery is that of computer technology. For example, there are experiments going on today using robots to perform surgery. In fact, I understand that a robot has been used to perform brain surgery.

Any area that requires precision is certainly one where robotics might have a good application. Think about all the routine activities in a dental practice--do you think a robot might function as a dental assistant or at least perform specific functions, perhaps better than humans? This may sound somewhat far-fetched to you, but this is not such a crazy idea--experiments are going on every day and robots are capable of performing all types of functions in an effective manner.

Digital subtraction radiography is another area which uses computer technology to read radiographs. With this new type of equipment, it is no longer imperative that radiologists interpret radiographs. A computer can do it and anyone who can read English would be capable of making the diagnosis.

You are all probably aware of the tremendous increase in the use of home computers. Think for a minute about how it may be possible in the future for home computers to do various types of testing and diagnosis at home, making it unnecessary for you as a patient to go into any type of health care office or facility. You could merely send the results of your tests and diagnosis over telephone wires to some type of central file.

Along this same line of thinking, there will be the ability, through computer technology, to develop community health profiles. Think of a centralized data base where you could record all the various information about your health. An individual health profile could easily be maintained. This would allow access to information about you and your health without having to go into any specific facility.

In addition, it would allow us to take a look at how community health patterns evolve and change, i.e., it would also allow us to develop new approaches to prevention problems. Let your mind think a little bit about how all of these various computer applications can bring about major changes in a very short period of time.

Another area relates to the explosion in medical/scientific knowledge. Based on what I have read, we are now seeing major breakthroughs that relate to a new understanding of how the human body works and how various substances work to intervene or detect disease. Just to give you some brief examples of several areas in which scientific knowledge has recently begun to make major 'breakthroughs':

-Substances that cause biochemical changes to help cure mental illness.
-Substances to combat memory loss (memory enhancers).
-The ability to generate new life through the laboratory (test tube babies).
-Substances that regenerate tissue.
-The use of monoclonal antibodies. These substances can actually detect certain changes in the body that will allow you to isolate specific diseases. It may be possible through the use of monoclonal antibodies to actually develop a means of testing for cancer at home. It may not be too long until you will go to your local pharmacy to purchase a kit allowing you to perform home cancer tests.

Go into your local pharmacy or drug store and look at the shelves and you will see some of the types of substances now being marketed, and you too will be overwhelmed. Home pregnancy testing is just the very, very beginning of major new scientific breakthroughs that will occur in the very near future.

Implications of the Changes

What are some of the implications of these changes? You have been charged with giving thought to how changes in the health care system may affect the future of dental hygiene. It is your task to determine what types of changes may have implications for your profession. Through the following points, I have outlined some of the major implications for the changes in where and how health care will be delivered in the future:

1. Changes will bring about new types of health care specialists and technicians and also conflict among existing health care professionals:
   -Pharmacist and nutritionist
   -Radiologist and pathologist vs. physicians

-Nurses vs. physicians
-Physician extenders vs. physicians
-Dentists vs. technicians

2. There will be new markets created for selling health-care equipment and services for individual home use.
3. Since more individuals will have access to computers, there will be major opportunities for computer-based self-instruction, self-diagnosis and self-treatment.
4. Health professionals will make use of computer applications for purposes of their own self-instruction and for developing patient instructional materials.
5. There will be the ability to determine broad community health status profiles which should stimulate health education and disease prevention programs (including occupational health related programs).
6. There will be major changes in professional educational training programs since the primary focus of dealing with health care will no longer be institutionally based but community and home based.
7. There will clearly be needs for continuing education for licensed health care professionals to keep up with the new technology use and applications.

Trends in Diseases

Another area relates to recent trends with regard to health status. Below is a brief summary that is broken down by disease trends among children (ages 0-14), adolescents and young adults (ages 15-24), adults (25-64) and the elderly (over 65). This summary is by no means all inclusive, but should give you an idea of some of the more significant trends that may have an impact on how our health care system could be impacted in the future. Below is a brief summary of these following four categories:

1. Children (0-14)
   -Infant mortality has decreased by 60% in the past 30 years. Mortality rates for black infants remains twice that for whites.
   -Although mortality decreased across all ages, the largest decreases occurred in children under 14. This is due largely to a decline in death due to natural causes.
   -Among children aged 5-14, cancer, particularly leukemia, has remained the leading cause of disease-related mortality. Particularly large increases have been made since 1970.
2. Adolescents and Young Adults (15-24)
   -This age group has the smallest decline in mortality from all causes. The small decline is due to an increase in homicides, suicides and accidents rather than an increase in disease-related deaths.
3. Adults (25-64)
   -For adults, mortality rates have decreased by one-third in the past three decades. The largest declines have occurred in deaths from heart disease and stroke.
   -Most of the progress in heart disease has occurred in the past 15 years.
   -The percent of adults tested for high blood pressure has increased substantially over the past ten years with the largest increase in testing occurring among blacks, who face the greatest risk of high

blood pressure. The increased testing corresponds with a decrease in the percentage of adults with high blood pressure and a decline in mortality due to heart disease. This is but one example of health education efforts leading to increased recognition of the importance of disease prevention.

-The number of cardiac catheterization procedures has increased. For men aged 45-64, the number of procedures performed has been increasing at a rate of 10% per year.

-Deaths from cancer have declined substantially in younger adults (25-44). Most of the decline has occurred since 1965. For older adults (45-64), the increase in deaths from cancer can be almost totally attributed to lung cancer. Between 1950 and 1980, mortality from lung cancer increased 2.5 times while mortality from other types of cancer fell 10%.

-Overall the death rate for men aged 45-64 is twice that for females in the same group. Men are three times more likely to die from heart disease than women. For cancer and strokes death rates are only 25-30% higher among men than women.

4. Elderly (over 65)

-In the past three decades, the death rate for this age group has declined 27%. Heart disease, cancer and stroke accounted for 75% of the deaths among the elderly in both 1950 and 1980.

-The decline in death rates has been greater for elderly women than for elderly men, thus increasing the difference between the sexes. In 1950 the mortality rate for men over 65 was 34% higher than for women of the same age. By comparison, the mortality rate for elderly men was 69% higher than for women in 1980. The most pronounced difference appears in deaths due to lung cancer. Men over 65 are five times likely to die of lung cancer than are women over 65.

-One-tenth of the population is elderly, but they account for one-third of all health care expenditures.

Reimbursement for Health Care Services

Reimbursement mechanisms for health care services are in the process of major overhaul. We have been used to a 'fee for service' system which essentially means that you pay for a service after it has been rendered, based on the type of service you received. We may continue to see some services still operating under a "fee for service" system, but it will no longer be the primary system of reimbursement.

What is clearly becoming more popular is a system whereby a set amount of dollars is authorized for an agreed upon set of services and these amounts are determined in advance. These types of plans are known as 'prepayment plans.' Some of the more familiar mechanisms that are using prepayment plans are as follows:

-Health Maintenance Organization (HMOs).
-Independent Practice Associations (IPAs).
-Diagnoses Related Groupings (DRGs)--this is the new system that Medicare has recently implemented.
-Other types of capitation and set payment schemes.

I believe that we are seeing a movement toward prepayment and capitation plans and that the payment mechanisms will have an impact on both how and where health care is delivered in the future.

Much of the health care cost issue is tied to reimbursement schemes. With this in mind, you can be sure that the current experimentation in new reimbursement schemes will continue and we will be witnessing various types of programs that are designed with incentives to change how the health care system is being used. Some of the recent programs that are being implemented as incentives to change how hospitals are being used, for example, include:

-Pre-admission screening programs
-Pre-admission testing programs
-Payment incentives for outpatient surgery
-Lower insurance rates for non-smokers, healthy people
-Higher co-payments to make individuals more price sensitive

Impact of Consumer Influences on the Health Care Delivery System

In looking at our overview of what changes we can predict in the future of our health care delivery system, we need to be very conscious of the impact of the consumer on this system. We are seeing a much greater awareness on the part of individuals being stimulated both by government and big business.

I believe that we should be taking a careful look at what the potential impact will be on the health care system as consumers are better educated and more aware of their own health and the cost associated with health care. The increasing emphasis on wellness will have an impact on how the health care system is used. And, finally, the role of big business and their approach to "the bottom line" may cause significant changes in our health care delivery system.

Summary Statement

We are in the midst of major changes taking place in the health care delivery system. As you look at the future and begin to plan for the dental hygiene profession, be sure to keep in mind the following:

-Changes in where health care is delivered.
-Changes in how health care is delivered.
-Changes in how health care services are paid for.
-Challenges of providing care to an aging population.
-Role of the individual in providing self-care.
-Implications for the health care professions."

After Dr. Kramer responded to the questions of the participants, they returned to their respective Workshop groups to identify those trends which would impact on the future of dental hygiene. The participants were also asked, if time permitted, to identify different roles that dental hygienists could assume to accommodate projected changes. The general assembly met and received the reports of the various groups. Those trends believed to be most important and pertinent to dental hygiene's future were:

1. Changes in Locations Where Health Care is Delivered.

Participants felt that greater use would be made of patient-centered health care delivery locations. This would occur as a result of increased emphasis being placed on providing health care in settings most accessible to targeted populations who are dependent on transportation or in-home visitations. The movement toward providing alternative delivery systems for all types of patients with special needs was seen by participants as a major catalyst for further expansion of the dental hygiene workforce into non-traditional settings.

Another factor identified which may provide impetus for change in work settings for the dental hygienist is the projected increase in the provision of health services in commercial enterprises. In these settings it is the organization that becomes the purchaser of health services. As a result, these organizations can and will dictate the role of health care providers and the type of service to be given. It can further be foreseen that large organizations or commercial enterprises will seek more cost effective ways to provide health care services to their employees. It was suggested that one of the major forces in the elimination of artificially imposed barriers now controlling the practice of dental hygiene may come about as a result of pressure from powerful corporations.

2. Changes in Consumer Demand for Cost Effective Health Care.

Again, as in the first session, participants felt that consumer demands for health care at affordable costs to both individual consumers and large business corporations will lead to changes in health care delivery systems with increased utilization of primary health professions. It was also suggested that public acceptance of the wellness concept would become a way of life. Further, once primary health care becomes equated with quality of life and public priorities are directed toward health maintenance, the significance of the dental hygienist's role will increase markedly. Research has already demonstrated that hygienists can be prepared to perform primary and secondary preventive services at a high level of quality. In addition, with minimal increase in community dental hygiene educational preparation, dental hygienists can become the major primary dental health care provider and promoter of preventive services.

Participants agreed that the cost effective dental delivery systems of the future will justify the need for recognizing the untapped resource potential that exists in the dental hygiene profession.

Participants also addressed reimbursement mechanisms for health care services in the discussion of cost containment. The majority of participants believed that experimentation with new and various types of reimbursement incentives will positively influence changes in how the health system will be used.

3. Changes in Technology

Participants addressed the effects of increased technology on the

diagnosis and treatment of disease, disease prevention and health care delivery systems. It was felt that the magnitude of technological change will create new demands on both dental hygiene educators and practitioners. It was recognized that because of the unpredictable nature of these changes, dental hygiene's future will be determined by its adaptability. Issues included in the discussion were the importance of: (1) possessing general knowledge, the nature of which is basic preparation for adaptability, (2) accepting continuous lifelong learning as an integral component for professional survival and (3) continuing to emphasize personal and humanistic values in the promotion and provision of health care in a highly technological society.

4. Changing Human Values

The concept of wellness as it relates to health promotion and disease prevention in a highly technological society was again addressed. The emergence of fitness programs, holistic health centers and personal and community self-help programs were cited as evidence of growing public interest in the wellness concept. It was envisioned that this changing orientation toward individual responsibility for health and self-care was compatible with the philosophy underlying dental hygiene practice and had the potential for becoming a viable option for role expansion.

Changing trends in health policy with power shifts from the established health professionals to consumers, from medical staffs to health care administrators, and from individual purchasers of health services to large corporations were viewed as positive factors, advantageous to dental hygiene's future. Consumer power was viewed as noteworthy since it is embodied in legislation. This was considered of significance as, historically, health professionals have been insulated from lay evaluation control. Participants were of the opinion that consumer involvement in the regulatory processes associated with health care would weaken political barriers that currently inhibit provision of comprehensive preventive services by dental hygienists in the majority of states. It was further projected that because the focus for providing health services will shift from office or institutionally based to home or community-based, dental hygienists will need: (1) to be prepared to function with the a broader perspective and knowledge of health, (2) to reach diverse populations in culturally accepted patterns, (3) to adapt to technologically sophisticated methods of health care provision; (4) to understand and work in new and different organizational relationships and (5) to provide primary preventive health services at affordable costs.

At the conclusion of the individual group reports on health care trends and their impact on dental hygiene, participants then discussed dental hygiene roles which were needed to accommodate anticipated changes. Although many roles were discussed, six general categories were identified and accepted by the assembly participants. They were:

A. Administrators/Managers

Participants believed that more dental hygienists should function in administrative or managerial positions in programs of health promotion

and disease prevention. It was stated that, philosophically, dental hygienists believe in and have had a long-standing commitment to promote the ideas implicit in the concept of prevention. Participants felt that more impetus would be given to preventive dental programs if more dental hygienists were employed to function in major decision-making roles.

B. Researchers

The need to increase the number of dental hygienists engaged in original research was seen as essential (1) to develop a codified knowledge base for dental hygiene and to extend the boundaries of the profession's body of knowledge, (2) to contribute to the creation of new knowledge for the benefit of society and (3) to become a respectable, established field of study. There was unanimous agreement among participants that both basic and applied research was needed.

C. Educators

The continued need for dental hygiene educators to function in public health or school programs and as faculty in dental hygiene programs was cited. In addition, need was expressed for more dental hygiene educators who have expertise in the areas of media design and production, computer programming of self-instructional materials for use by consumers and other health care providers, and communication theory and marketing strategies. Also expressed was the need for dental hygiene educators to promote concepts of prevention in community-based programs designed for specific population groups.

D. Clinicians

The need to extend the service role of the clinician to more effectively deliver quality dental hygiene care was identified. Basic to establishing the dental hygienist as the primary provider of preventive services was the need for clinicians to have special knowledge and expertise to adapt dental hygiene treatment plans to meet the preventive needs of special populations such as the institutionalized, chronically ill, homebound and elderly. Within this context the need for a clinician specialist was recognized. Further, it was felt that if dental hygienists were to accommodate the needs of underserved or unserved populations, dental hygiene practitioners need to move into roles involving experimentation with, and implementation of, new delivery modalities. Involvement in such roles was viewed as primary to dental hygiene's ability to play a significant role in the determination of how, where, and by whom primary and secondary preventive services will be delivered.

E. Patient Advocates

The role of dental hygienists functioning as patient advocates was considered important in advancing the concepts of health promotion and disease prevention. Participants felt that dental hygienists could perform valuable services to individual and consumer groups and to businesses and governmental agencies in support of health care efforts. Advocate roles dental hygienists could perform include: monitoring

quality in public dental programs, assisting consumer groups in obtaining access to dental care, monitoring dental referral systems, developing periodontal disease screening centers, consulting with consumer groups on benefits and limitation of various health reimbursement policies and monitoring individual and group self-care programs.

F. Change Agents (Enablers)

The need for more dental hygienists prepared with knowledge and skills to be effective change agents was recognized. It was felt that the number of hygienists with the academic credentials and credibility needed to lobby or to legislate changes in health care was inadequate. Further, it was envisioned that more dental hygienists would need to function as professional change agents to diffuse new ideas and to integrate innovations into the future health care system.

Third Session of Workshop I

In the third presentation during Workshop I, Dr. Carol Lindeman focused on the relationship between current views and values of society and those of established health professions, the implications of the difference between society's expectations and the health professions' traditional perceptions and goals and the need for change in health professions if they are to continue to be valued by society. Dr. Lindeman's presentation follows:

HIGHER EDUCATION AND THE HEALTH PROFESSIONS

Issues and Trends

Carol A. Lindeman, RN, PhD, FAAN, Professor & Dean
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"My presentation is organized into three main sections. The first section is a brief sketch of potential collision courses between the traditional thinking of health professionals and current views within society. The second section deals with the nursing profession as a case study of a practice group moving toward full professional status. The third section attempts to identify broad recommendations for dental hygiene as it examines itself according to criteria for 'professionhood'.

Discussion

To begin, I wish to share some of my thoughts regarding dental hygiene. Some of these thoughts are generated from contact with the dental hygiene faculty on our own campus, some from casual interviews with the dental hygienists who have cared for me over the years, and some from the literature.

My perception is that you are becoming a very active group with great leadership potential within your ranks. It also seems that in many ways you are experiencing and debating the problems and frustrations common to any emerging profession. Perhaps I am inaccurate in this assumption, but I believe professions are made--they are created by humans, not by divine inspiration. They mature through the hard work and vision of people from within the profession who have a commitment to a new or better service to humankind.

The one disadvantage that I see in your struggle is that you are examining yourself in terms of professional status when dentistry, your collaborative group and the group society associates you with, is itself at a critical point in its development. I am not referring to the economic concerns of dentistry but to the questions regarding the nature of dentistry and whether it is a behavioral science, an applied discipline with the basic sciences as the base of practice, or a technical field of study and practice. I am referring to the question as to why dentistry has practiced independent of the other health professions with which it has claimed kinship. It is more difficult to develop autonomy and a clear sense of identity when parents and significant others are doing the same thing.

It is evident from daily newspapers and lay journals that society, the public and the health professions do not see eye to eye on a number of issues. Cost of health care is discussed weekly if not daily with the public taking the position that costs can and should be controlled. The medical profession, on the other hand, takes the position that any reduction in dollars will result in poorer quality of care with perhaps more dire consequences. Access to health care is another topic of interest, with the public claiming that the health care system is too complex and self-serving while health professionals claim it is the best the world has ever known.

As important as these areas of conflict are to society and its health professionals, they are not the collision courses that I would like you to reflect on today. I would like you to reflect on ownership of knowledge, self-care, control of practice and scope of practice.

First, it seems to me that we have been for some time on a collision course regarding knowledge and who owns it. The computer with all its wonderful potential has accelerated this area of conflict between the professional and the public. To appreciate my point, I ask you to remember that the human race did not always have the same easy access to knowledge as we do today.

Think of the world before the printing press. Think of the world before the telephone. Think of the world before the automobile. Think of the world before television. There was a time when knowledge was held by a few--the technology to enable ownership by the masses was not there. It was simply not practical to assume that any massive amount of knowledge could be disseminated to the public.

This has changed over the years and is changing more rapidly with the recent advances in technology. People can and do learn without teachers! Want to write a will or get a divorce? You no longer are limited to hiring a lawyer, you now can go to the bookstore and purchase a self-help, step-by-step guide. Need your x-ray read? Let the computer do it fast and effectively. Want a history taken? Have a client respond to questions posed by the computer. Worried about drug interactions? Ask the computer.

My point is that not only are we a well-educated country, but in recent years technology and research have reduced barriers to dissemination of knowledge to the extent that society sees no reason why it shouldn't have access to the same knowledge base as professionals. Health professionals would like to hang on to the good old days when patients did as they were told; didn't seek second opinions or go to the library and read about the diagnosis, etc. Frankly, I think those days will never return. Knowledge belongs to society at large and in the next decade we will see the effect of this on the interactions between health professionals and their patient/clients. Criteria for professionhood is not just acquiring knowledge, but qualities regarding the use of it.

A second collision course between the public and traditional health professionals is in the area of self-care. This is not independent from the issue of knowledge control, but does represent a value apart from it.

The American people are displaying a belief in a grass-roots approach to many aspects of life. Political campaigns have at least an outward appearance, if not a real shift, toward grass-roots involvement. People are forming self-help groups that range from building houses together, to carpooling, to caring for each other's pets, parents, or children to enable more leisure time without worry.

Intrinsic to this movement and value system as it is played out in health care is the belief that one could and should assume responsibility for one's own health and do more in terms of self-care during illness. Although health prevention and promotion are a part of this value, they are not the sum of it. People are choosing to die at home in the care of relatives rather than in the hospital in the care of professionals. People are seeking humane treatment that has a personal component; they are seeking care that continues to reflect a respect for the person and an assumption that the individual is able to participate in decision making about their own care.

Self-care, as it is unfolding here in the United States, is a value that stems from the belief that power and respect are with the grass-roots level of society. This is a shift from believing that health professionals are infallible and treating them as such.

We are also experiencing differences between health professionals and the public over the issue of control of practice. Society has raised serious questions about the self-interest of health professionals.

Questions have been raised specifically about profit in the health care

system and the fees charged. Questions have been raised over the failure to allow nurse practitioners greater opportunity to practice. Why should the public be denied access to that care when the data support the quality of the care they provide? Can one profession be trusted to allow another to emerge or will territoriality and monopolies characterize decision making?

Because of questions and concerns such as these, the public is demanding greater roles in review boards, licensing processes, etc. On the other hand, professionals are trying to hold to peer review groups.

The last collision course that I will mention is one regarding scope of practice. Society is changing; it does not want to be held back from potential improvement in the quality of living. Furthermore, it does not want to be led down a path where science and technology control and limit life rather than free life. Those groups that do not define themselves broadly and in futuristic terms will be left behind.

Society is pushing questions regarding the time-limited nature of some professions. Dentistry is one of the professions in question. Professions like dentistry are in a dilemma regarding the need to create a definition of practice that will hold in a dynamic world. Society expects professionals to move with society, indeed to lead the way. Traditional professionals would like society to hold still and value the service they deliver.

I have belabored these collision courses and labeled these areas as such out of the conviction that these issues will influence the next generation of professionals here in the United States.

It seems more than apparent that the United States is a rapidly changing society, and that a changing society has changing needs and values particularly in terms of education and health care. It seems more than apparent that in this changing environment, a new definition of professional and professionalism will emerge and the criteria of the past will serve only partially to define the future. And finally, it seems more than apparent that new or emerging health professionals must look to the future, not the past, for answers to their questions; they must look to society, not to other professions, for answers to their questions.

Perhaps I feel so strongly about this interplay between society and the health professions because of my experiences within nursing. In my mind, nursing is a profession and offers a service far more complex and important than even most nurses comprehend. The humanistic, caring part of health care is an extremely important service to society. It is more than intuitive.

Yet by the actions of those within the profession aided by some outside the profession, nursing has managed to keep that understanding a secret from many, and nurses remain our country's most underutilized resource. Let me share some observations about nursing as a case study illustrating a convoluted progression toward becoming an unambiguous profession.

Nursing, as it developed under Florence Nightingale in Europe, had four characteristics that are important in the context of this case study. First, the services offered were clearly linked to societal need. History suggests that this point was periodically reinforced by Nightingale to remind the public of this fact. On at least one occasion she withheld nursing care until the public demanded that it be available. Second, research and program evaluation were part of practice. Every practitioner collected data to evaluate care, to advance knowledge, and to inform the public as to the value of the significance. Third, Nightingale insisted that nurses would train nurses--it was imperative that the profession control its education. And fourth, although nurses controlled their own practice, they practiced within the realm of collaboration with other professionals (particularly with physicians).

Well, with that beginning, why is nursing in the mess that it is in today? Part of the answer to that question comes from the way nursing began here in the United States in contrast to Europe. Here in the United States, nursing educational programs were housed and financed in the employment setting.

Almost from the beginning, the employment setting, not the profession, controlled both the education and the practice of nursing. It was quite a monopoly and a power hold on those entering the profession.

In part this resulted in the educational preparation being modeled after vocational education, apprentice-type training with an emphasis on doing rather than knowing. Physicians rather than nurses controlled the educational programs and defined practice. Soon nurses became the handmaiden to the physicians--not the care providers that Nightingale had envisioned.

This start was bad enough for nursing in the United States. Worse yet was that nursing did not keep pace with other health-related disciplines. Physicians were relatively quick to bring about reform in their educational program. They increased admission requirements, housed their programs in universities, emphasized research and limited supply.

Nursing did none of these things, although since the 1890's it was urged to do so. Nursing also suffered from the continued devaluation of women and women's roles and contributions. This devaluation mentality external to the profession, and the internal mentality that refused to institute reforms, led to a self-fulfilling prophecy for the profession of nursing. Nursing practice in the United States slipped even further away from the Nightingale model.

By the 1940's there was confusion regarding human values and economic realities with nursing viewing them as good and bad, and wrong. To work for little was good; to be well paid was bad, etc. There was confusion regarding the goals of practice with some believing that nurses were created to serve physicians, not the patients.

World War II and the move of some schools to major universities rekindled the move toward full professional status. During World War II, nursing was declared a profession and nurses were considered a national resource. Nurses in the post-war era gave serious thought to the criteria for professional status and moved to meet each one. Let me review those criteria using the comprehensive listing by W. J. Goode, in his article, "The Profession: Reports and Opinions" (Am Soc Rev 25:902, 1960).

Goode identifies two characteristics as essential--a prolonged, specialized training in a body of abstract knowledge, and a service orientation. He then offers more specific characteristics:

-Profession determines its own standards of education and training.
-The student goes through a more far-reaching adult socialization experience than the learner in other occupations.
-Professional practice is often legally recognized by some form of licensure.
-Licensing and admission boards are manned by members of the profession.
-Most legislation concerned with the profession is shaped by that profession.
-The occupation gains in income, power and prestige ranking and can demand higher caliber students.
-Practitioner is relatively free of lay evaluation and control.
-The norms of practice enforced by the profession are more stringent than legal controls.
-Members are more strongly identified and affiliated with the profession than are members of other occupations.
-The profession is more likely to be a terminal occupation.

The U.S. Labor Relations Act defines 'professional work' as:
-Predominantly intellectual and varied in character.
-Involving the consistent exercise of direction and judgement.
-Output cannot be standardized.
-Requires knowledge of an advanced type in a field of science or learning acquired by a prolonged course of specialized intellectual instruction.

<u>Where is Nursing Today?</u>

Educational reform is well underway. Apprentice-type training has been eliminated and sound academic programs have been instituted. Admission requirements are high. Programs are housed in institutions of higher education and graduate programs, research and scholarship are growing rapidly. An earned doctorate is required for faculty status at the major nursing programs across the country. In addition:

Nursing has redefined itself as the science of health with greater emphasis on human response to illness status. Family and community are also focuses for practice. Definitions of nursing used within the profession and by state nursing boards treat nursing as an independent practice.

Schools of nursing are pursuing links with clinical care settings as a means of increasing their influence, power, reality orientation and economic base.

Nurses are politically active. Last year federal dollars for nursing research almost doubled. The Nurse Training Act has been kept alive. The study of nursing mandated by Congress and conducted by the Institute of Medicine was positive regarding the importance of nursing.

The image of nursing is slowly but surely changing. Nurses value their own practice and are demanding adequate pay. The American Hospital Association has urged that nurses control nursing practice and appropriate governance structures be implemented in hospitals. Nursing is understood as more than doing--the image of the nurse as a 'clinical decision maker' is emerging instead. Nursing is understood as more than a practice--its academic and research base is also valued.

Yet, not all is well within the profession of nursing. For example:

The profession has not been able to unify educational requirements for entry into practice. The issue is a major one as it could determine the way the profession will be classified in the 'information era'. Nursing, because it is an emerging profession, is still under review by society. In the 'information era', nurses could be categorized as 'knowledge workers' or as 'technology workers'. The decision about educational preparation will be a deciding factor. In this context, the career ladder concept only confuses the issue. It is unlikely that career ladders will span the technology worker/knowledge worker dichotomy.

Leadership is either lacking or pulling in opposing directions, and one strong voice for nursing remains an unfulfilled dream. The collective bargaining role of the American Nurses' Association remains a source of conflict. The National League for Nursing's support for all levels of nursing education remains a source of conflict. The growing strength of the specialty organizations generates mixed reactions.

Supply and demand projections and experience bounce from undersupply to oversupply in relatively short time frames. It is clear that the nursing employment sector is influenced by forces only partially understood by nurse educators or the nursing leadership. There may well be too many nursing programs as student demand is decreasing. With many more options available to female students, nursing will have to learn how to compete for top level applicants.

The list of unresolved issues could continue, but we are here to focus on dental hygiene education. You are making a conscious choice about the future of dental hygiene--practice and education. You will attempt to resolve issues regarding education as it fits into your picture of yourself (role, etc.). Your hopes for your profession are exciting, socially significant and attainable. But--are you willing to take the

risks involved with those hopes? Being a risk-taker is where the route to professionalism begins!

Recommendations

Dental hygiene issues, as I see them are as follows:

1. Commit yourself to your goals and move. There will always be reasons why you shouldn't do something, so don't let the woe-bearers stop you. Bite the bullet. Move. Don't try to make everyone happy. Negotiate but don't compromise to a lukewarm nothingness. Be driven by your dreams and the future!

2. Where to house your educational programs? Should your programs be housed in service settings or educational settings? In community colleges or universities? Should they be linked with dental schools? Should they be two or four years in length?

   From my perspective in nursing, I would urge that you set your goals higher rather than lower, or by the time you get there society will have moved farther, faster and you'll be at the low end of the educational pole. But you must decide. Do you see dental hygienists of the year 2000 as technology workers or knowledge workers? What maturity is necessary for professional practice? What socialization time and experience? What is the breadth, depth and scope of the general or liberal arts knowledge and of professional knowledge that is desirable? What clinical decision-making skills must be acquired? What research skills? And if they are going to be change agents (and most of them are women in a male dominated health care system), what credentials do they need to give them social and political clout?

3. Graduate education and research. For the nursing profession, major strides forward occurred as a result of developing graduate and research programs, and the insistence that graduate education be within the discipline of nursing. I urge you to consider a similar approach. Create a systematic plan for developing graduate education in dental hygiene an carve out a statement of philosophy or of goals for research in dental hygiene. Your research efforts may begin in a small way, but begin! Get your research before the public. Change your image!

4. Control of practice; scope of practice. It is critical that you control your own practice. It is also critical that you define the scope of practice in keeping with trends within society. Control may have to be shaped with society, but hopefully not with or by another health profession.

5. Faculty qualifications. Continue to upgrade faculty qualifications as you upgrade programs and student entrance requirements. It is all part of the package of reaching and maintaining the status of 'profession'.

6. Create a multidimensional strategy to implement your decisions. Your strategy needs to include:
   -Changing your public image.
   -Changing your image within your own discipline (membership).
   -Determining possible coalition.
   -Decisions on staging and time frame. Identification of prime target groups, with specific message for each group.

Conclusion

In conclusion, I wish only to say that it is exciting to be at a turning or growth point. It is painful in some respects, but mostly it is exciting and fun. You are at a turning point--in part because you have created one and in part because society has a newly identified need of your services. You have the potential within your membership to accept the challenge and move into full professional status.

As a member of a society that needs your professional services and as a member of the emerging profession of nursing, I hope you choose to move your dreams into reality."

Dr. Lindeman's statements that, "Those groups that do not define themselves broadly and in future terms will be left behind . . . ", and ". . . the need to create a definition of practice which will hold in a dynamic world, . ." evoked an expression of affirmation by the participants. After a brief question and answer period, discussion groups convened. Four major areas of consideration were assigned to provide the framework for developing consensus on philosophy and goals for dental hygiene education. The four areas: (1) Knowledge Worker or Technology Applier, (2) Educational Program, (3) Research and (4) Student Qualifications, represent issues that are considered central to the question of what direction dental hygiene education could take to establish dental hygiene as a profession within society at large and within the recognized professions. The discussion groups were asked to make the choices necessary to determine future directions.

The assembly convened and received the reports of the individual groups. During the discussion that followed, agreement of the assembly was reached on the following:

Dental hygiene and dental hygiene education must change. Conditions of society, including priorities for health care resources, society's values and the responses of established professions and systems clearly forecast the need for different roles and thus different educational preparation.

Dental hygiene should take responsibility for its future. If is does not, it will continue to be used as a buffer while the health care delivery system and the professions, particularly dentistry, strive to maintain status and viability. Dental hygiene should not depend on dentistry or other groups to determine its future, but should assume responsibility for changes that will respond to societal trends and needs.

Decisions based solely on self-interest will not assure a future. Dental hygiene's direction must be congruent with society's values and needs. Dental hygiene is capable of fulfilling roles that are important to society now, and has the potential to adapt that capability as changes in priorities, systems and resources occur.

Dental hygiene education must advance. Decisions of the 1940's and 1950's no longer apply. Dental hygienists need more and broader education for today and the future with emphasis on knowledge rather than technical training, as knowledge foster flexibility.

There was general enthusiasm expressed that the dental hygiene community was addressing issues as a group that are germane to assuring a future for dental hygiene.

Deliberations during previous discussions provided background for developing consensus on the issues. Although group reports indicated total assembly agreement on several issues, it was considered important to provide opportunity for reconsideration after assembly discussion rather than assume consensus. This procedure allowed all participants additional opportunity to voice opinions and indicate positions. As group leaders presented reports, it became evident that some terms had been defined or interpreted differently by the groups. Consequently, the total assembly did not achieve consensus on some issues or questions.

1. Knowledge Worker or Technology Applier

All groups took the position that dental hygienists should be knowledge workers rather than technology appliers. The assembly unanimously affirmed this position. Discussion focused on the need to define dental hygiene broadly and to reinforce preparation of graduates for major roles as health promoters if dental hygiene practice is to be linked with society's needs and values. There was agreement that provision of clinical services would continue to be important, but that the importance and value of hygienists' traditional health promotion and prevention roles are becoming increasingly pertinent.

Participants also identified the need to redefine or refine education to focus on the theoretical basis for educational and clinical services if dental hygiene is to overcome its technician image. Breadth and depth in social sciences were seen as essential to preparing hygienists who are capable of fulfilling roles identified in the second session of Workshop I. Some expressed the opinion that it is the health promotion role that provides dental hygiene's unique characteristics , and that those characteristics and the ability to adapt to change are critical to its future.

The need for integrating data collection and evaluation into practice dictates a theoretically based education versus technical training. The advancement of knowledge regarding people's behavior, maintenance of health, and disease origins and processes, requires a far greater understanding of social and biomedical sciences than was required when

the existing framework for dental hygiene curricula was constructed in the late 1940's.

The relationship between research potential and education was discussed. Participants expressed the view that dental hygiene research was essential if professional status is to be attained. There was agreement that basic education should provide the foundation for subsequent acquisition of the ability to develop new knowledge through scientific inquiry. While all dental hygienists will not embark on research roles, all should have background to apply research in their chosen role. Advanced study which includes development of research skills should also be available. Participants recognized that knowledge or theoretically based education was critical to applying new knowledge in practice and establishing new roles which would be valued by society.

2. Educational Program

Six questions or choices were identified for discussion of the educational program for the future. Participants were asked to indicate their position or choice on the basis of what they believed important to the development of dental hygiene as a true profession, valued by the essential to society. The six questions were:

(A) Should programs be offered in service settings or education settings?
(B) Should the entry level of programs in the future be Associate Degree or Baccalaureate Degree?
(C) Should preparation for various roles be provided via career ladder curricula or a basic program?
(D) Should the curricula be general in nature or be discipline specific?
(E) Should dental hygienists' socialization occur within the program or after graduation in practice?
(F) Should graduate education be designed for role development or clinical development?

Some groups did not discuss all questions either by choice or due the lack of time. Interpretation of some questions and/or terms varied among the groups. Leaders provided their group's definitions when reporting to the assembly.

Some participants expressed concern about the expectation that the assembly indicate its position or choice. The suggestion that additional choices be interjected in the general session consensus development process was rejected by a clear majority of the participants. It was felt that there was adequate basis for expressing a position or opinion, and that decisive opinions were indicated.

Recognizing that there was more divergence on these issues than on considerations of previous sessions, it was decided by the body of participants that the assembly formally indicate a position on some issues by vote. Where votes were taken, actual numbers will be reported. Consensus and minority reports will also be reported.

A. Service or Education Setting

Group reports indicated a decisive position on the appropriate setting for dental hygiene education programs. The consensus reflected in the reports was affirmed by the assembly. Participants believed that it is critical that programs be offered in institutions of higher education which have resources and goals that are compatible with goals for dental hygiene education.

The need for dental hygiene to control its education was reiterated a number of times. Participants expressed concern about the extent to which the existing educational system is controlled by the service setting in the form of dentistry's perception's of the dental hygienist's role and limitations. The resulting technical orientation of curriculum standards was indentified as a barrier to advancing dental hygiene through modification of existing roles and development of roles.

The need for a broader knowledge based education to provide flexibility and assure viability as society's priorities change was identified. Participants expressed the opinion that educational institutions which offer broad, liberal education were appropriate settings for dental hygiene education. The need to move away from totally job-oriented technical education was seen as critical to the future.

B. Associate Degree or Baccalaureate Degree

The question of appropriate entry level education for the future evoked more discussion during the general session than any other of the six questions considered in group discussions. The assembly expressed a clear and unanimous consensus that entry level education in the future should be more than the two years of college which is prescribed for an associate degree. Participants noted the fact that existing "two-year" dental hygiene programs, by and large, are three academic years in length. Some expressed concern about the dilemma dental hygiene educators face in offering curricula designed to adequately prepare graduates for practice when technical and community college administrators are pressing for limits on the length and scope of curricula and prerequisite education. This dilemma was recognized as one that must be addressed. Individuals offered comments on some approaches to resolving the dichotomy between institutional philosophies and goals, and the goals and needs of curricula such as dental hygiene. Innovations in providing education were cited by a few. The assembly did not attempt to provide answers, but affirmed the position that the two-year dental hygiene program is an aberration and that existing curricula are evidence that more than two years is needed to prepare dental hygienists for practice today, let alone in the future.

Six of the seven groups reported consensus on the position that baccalaureate degree curricula should be the future entry level for dental hygiene practice. Two minority reports stating that the level of education should be more than the associate degree, but that it was premature to specify baccalaureate degree entry, were received. The

seventh group did not come to closure on this issue and elected not to report a position.

In the general session the majority of the assembly (68) took the position that the baccalaureate degree should be the entry education requirement in the future. None of the participants took the position that the currently prescribed entry level of a two-year associate degree should be retained in the future. Twenty-nine (29) participants abstained from voting. Reasons for abstaining offered by some were: (1) the length of education and degree should be identified after curriculum content is specified, (2) entry level education beyond the baccalaureate degree may be required to prepare hygienists for future roles which are as yet undefined, and (3) the length and level of education should be somewhere between that of an associate degree curriculum and that of a baccalaureate degree curriculum.

C. Career Ladder or Basic Program

Those groups which addressed the question of whether preparation for entry into practice should be provided through career ladder curricula or broadly inclusive basic curricula interpreted the terms differently. Some considered the career ladder to be within dental hygiene, others included other fields as part of a hypothetical ladder. The four groups which reported agreed that there should be one basic program for entry into the field of dental hygiene. Participants again felt that it was critical that there be one level of education for entry into practice, thus all preparation for practice must occur within a basic program with a single exit point. This position was not viewed as precluding acceleration for particularly able students, or advanced placement provisions.

The relationship between recognition as a profession and the structure of educational programs was considered. Education that encompasses advanced knowledge in the field which is acquired by a prolonged course of specialized intellectual instruction is one of the characteristics of a profession discussed by Dr. Lindeman. Participants expressed concern that development of a career ladder within dental hygiene education would result in different levels of practitioners, some of which would be considered occupational rather than professional in nature. Participants who expressed preference for a career ladder were referring to curricula which would be articulated with curricula in other disciplines, such as dentistry. The effect of constructing curricula to provide such mechanisms was discussed. Participants expressed the view that there was need to develop basic programs that provide background for graduates to fill a variety of roles identified as dental hygiene. Such flexibility would provide satisfaction prevent obsolescence and promote recognition of dental hygiene as a profession that is valued by society.

At the conclusion of discussion a vote of the general assembly was taken. The Career Ladder received no votes (0), the Basic Program received 81 votes and 10 were recorded abstentions were recorded.

D. General Education or Discipline Specific

Reports of group discussions indicated significant differences among the groups in defining the terms "general education" and "discipline specific". Recognizing the difficulty that would be encountered in attempting to arrive at a consensus in the general session, the assembly elected to record the following positions:

> An educational base upon which to build dental hygiene courses is needed.
>
> A broad base of education that enhances the quality of education in our discipline is needed.
>
> The group reached consensus for discipline specific education in order to create our own body of knowledge.

In reviewing the positions taken by groups on their interpretation of the issue, there is evidence of common philosophy which is consistent with the participants' positions on the location, nature and level of education programs.

Groups that defined general education as a broad education including in-depth courses in social and biomedical sciences and the liberal arts, and discipline specific as a narrow education with applied courses specifically designed for dental hygiene students agreed that dental hygiene education should be general in nature. It was recognized that a broad, in-depth education is consistent with the position that dental hygiene should be knowledge based. It was also recognized that flexibility to adapt to change is dependent upon a broad education base. Some voiced the opinion that while specialized education might appear to be economical and expedient, broad based education was more efficient and cost effective in the long term to prepare individuals for practice in a rapidly changing society. Broad based education was considered important to meeting society's needs today as well as in the future.

Those groups that defined general education as that which leads to a degree in other fields or a non-specific degree, and discipline specific as education leading to a degree in dental hygiene took the position that curricula should be discipline specific. They considered development of curricula which leads to a degree in dental hygiene important to recognition of dental hygiene as a profession. The provision of baccalaureate degree education in the discipline as the precursor to programs leading to graduate degrees in dental hygiene was recognized as essential. Some voiced the opinion that promotion of baccalaureate and graduate education in other disciplines is contradictory to the historical development of established professions. Others indicated that without discipline specific baccalaureate and graduate education, dental hygiene would continue to be technology based. Those who expressed support of general education in this context saw it as a means of facilitating career changes.

E. Socialization in Education Program or in Practice

The groups were asked to consider where socialization should occur to develop identity and maintain the individual's commitment to dental hygiene. There was agreement among the five groups that discussed the question that socialization should occur within the education program. This position was based on an awareness that if socialization or career shaping takes place in the work setting, identity with and the bond to the specific discipline is diffused. Participants expressed the belief that commitment to dental hygiene is directly related to the identity that is established in education programs that are discipline specific. If education leads to degrees in other areas, identification with dental hygiene is lost or diluted as identity with the new field is developed. The interdependence of discipline specific education and socialization was seen as an important concept to consider in establishing goals for the future. The need for developing identity and commitment to dental hygiene was reiterated in other workshop sessions. The assembly gained general consensus that socialization should occur in the education program.

F. Graduate Education: Role Development or Clinical Development

Three groups addressed the question of whether the goal of graduate education should be role development or clinical development. There was agreement among the groups that graduate education should focus on role development and that clinical development should occur in the entry level program. The need to develop new or modified roles for dental hygienists was seen as a priority. Further, participants voiced the opinion that preparation for some of the roles identified in the second session of Workshop I required realization of the relationship between society's needs and dental hygiene's potential. Such realizations are the result of theoretical considerations and their application to the discipline. It was recognized that graduate education designed for clinical development would result in narrow specialization that would not differentiate dental hygiene as unique, but would duplicate dentistry.

The rationale for undergraduate programs in the discipline of dental hygiene were considered particularly pertinent to graduate education. The need for advancement of knowledge in the field was considered critical, and participants recognized that such advancement is a major goal and will be the product of the research component of graduate education. If graduate study is pursued in other disciplines, research efforts contribute to knowledge of that discipline. As in undergraduate programs, the student identifies with, and is identified with, the field of study. Advances are attributed to and enhance the given discipline. General consensus on role development rather than clinical development was reached by the assembly.

3. Research

The importance of research to the advancement of dental hygiene was not questioned. Participants agreed that development of research goals should have high priority. It was recognized that development of new

roles, provision of knowledge based education and recognition as a profession are directly dependent upon the extent and focus of research efforts. It was also recognized that graduate education and research and interdependent, and that research designed to develop a body of knowledge identified as dental hygiene is essential.

The importance of research that focuses on dental hygiene was reiterated. Dr. Lindeman's admonition to "create a systematic plan for the development of graduate education in dental hygiene and carve out a statement of philosophy and goals for research in dental hygiene," was seen as advice that should be heeded.

Research in the form of data collection and evaluation in practice was also considered essential to the development of new modalities of care and formulation of plans for carrying out services associated with various roles. It was recognized that research in this form fosters the transition from doing to decision-making.

Several participants expressed the view that research should be focused on areas which are compatible with dental hygiene's goals and society's priorities, and that it should be directed in areas of the dental hygienists' expertise. To compete with well developed disciplines and attempt to conduct research in areas that require a high level of knowledge and sophistication in those disciplines would not enhance dental hygiene's image and recognition as a profession.

The three groups that considered whether research should be directed to improving life versus techniques agreed. They believed that efforts should be expended in projects related to wellness or improving and maintaining health rather than technical procedures for treating disease.

4. Student Qualifications

Three groups discussed three topics which were grouped under Student Qualifications: caliber, recruitment and control of admissions. It was generally recognized that each of these is a critical factor in meeting goals for the scope and level of education. Although all groups did not discuss the topics, the discussion by the assembly following the reports of those groups indicated that the assembly was in agreement with the positions which were presented. Also, the assembly indicated that student qualifications and recruitment should be given priority in education program planning.

There was consensus among the groups that there is need to raise the caliber of dental hygiene students. Students' academic preparation and individual capabilities were cited as areas of concern. There was agreement that the caliber of students entering dental hygiene has lessened over the past several years. Participants attributed deterioration of the applicant pool to several factors including: lack of intensive recruitment programs; competition with other disciplines, particularly established professions; the movement of women toward traditionally male professions; dentistry's concerted efforts to recruit women, specifically potential dental hygiene applicants and lack of

control of admissions by dental hygiene. Philosophies and policies of some educational institutions were seen to have an adverse effect on the caliber of students.

There was consensus that a change in philosophy and increased efforts would be needed to address what was considered a critical problem. The need for dental hygienists to be more positive about dental hygiene and the future, and active recruitment of students were identified as parts of the solution. Creation of a better image of dental hygiene and changes in education which would result in more flexibility to meet challenges and carve out new roles were seen as critical. Some participants cautioned that without concurrent change in dental hygiene education and practice, the results of recruitment efforts would be severely diminished.

The need for dental hygiene to control admissions was seen as equally important. Participants expressed the view that, without that control, standards could continue to deteriorate. Control of admissions was seen as the key to knowledge based education.

Evaluation of Dental Hygiene Education Workshop I

At their planning meeting held in Chicago, Illinois in October, 1984, the Steering Committee discussed the major strengths and limitations of Workshop I. Major strengths included participants, the level of success of the Workshop, the progress made and the increasing interest in the Workshop. Limitations of the Workshop included timing of notice of the program, limited publicity, organization of group leaders, and lack of an on-sight formal evaluation process.

The participants represented practitioners and educators who demonstrated the ability to work together. Participants demonstrated leadership by this willingness to face the issues and make changes to advance dental hygiene. Considerable progress was made even though a great deal was at risk.

Comments by participants suggested that Workshop I was successful. Many issues discussed were emotional but participants were willing to discuss them. Increased interested in participating in the Workshop II has been suggested through responses from the evaluation questionnaire, and contacts made to ADHA officers, staff and members of the Steering Committee.

Results of the Evaluation Questionnaire

The evaluation questionnaire was designed to evaluate the workshop goals, format, geographic location, hotel accommodations, registration procedures and fees, and arrangements for the reception, luncheon and breaks. Participants were asked to identify three strengths and three limitations of the workshop. In addition, they were asked to make any other comments not covered on the questionnaire.

Method

Questionnaires were mailed to 98 participants on November 1, 1984. Members of the Steering Committee, ADHA Officers, and staff did not participate in the questionnaire evaluation. There were 64 questionnaires returned which represents 65.3% of the participants.

There were 21 questions requiring responses about the degree of satisfaction which ranged from one to six. Responses numbered one to two indicated respondents were very satisfied; three to four indicated moderate satisfaction; and five to six indicated dissatisfaction.

Results

The results of the responses to each question were tabulated and a mean response for the 21 questions was 2.19. The median was 2.17 and the range was 1.71. The results of the tabulations for each question appear in the evaluation summary which is in the Appendix. The individual responses, total response of questions, and mean score per question are included.

In responses to questions one through three regarding the extent to which the three goals of the Workshop were met, moderate satisfaction was indicated. The mean scores for the three goals was 2.92.

Question four had four parts, and respondents indicated they were very satisfied with the speakers in terms of providing appropriate background and scope to support the goals. The mean score for the four parts to the question was 1.93. Respondents indicated moderate satisfaction with the bibliography which provided background for the workshop goals in question 5. The mean score was 2.26.

Questions six through nine identified the respondents' satisfaction with the level of interaction in the general sessions and small group discussion sessions, the effectiveness of the nominal process, and the role of discussion leaders in facilitating discussion. The mean score for these four questions was 2.44 indicating that respondents were moderately to very satisfied. There was a high level of satisfaction with the size of the discussion groups as responded to in question ten. Moderate satisfaction was indicated for the Workshop format as an effective means for arriving at consensus in question 11. Time allocations for general sessions and small group sessions illicited moderate satisfaction with a mean score of 3.21 in questions 12 and 13.

Respondents indicated they were very satisfied with the location of the Workshop and local arrangements. Questions 14 through 21 had a mean response of 1.84. Question 22 asked respondents to identify three strengths of the Workshop. There were 13 categories of strengths identified from a total of 158 responses. Table 1 contains a list of all categories of strengths with the corresponding number of responses. The three speakers were identified as the major strengths of the Workshop by 31 respondents. The content of the Workshop was selected as the second major strength by 27 respondents and the third major strength was the format of the Workshop (listed by 20 respondents).

Table 1: Ranking of Workshop I Strengths Based on Total Responses

Ranking	Strengths	Responses
1	Speakers	31
2	Content	27
3	Organization	20
4	Representation	18
5	Nominal Process	17
6	Moderator/Group Leaders	10
7	Location/Accommodations	8
8	Discussion Groups	7
9	Goals and Objectives	6
10	Participants	5
11	Time Schedule	4
12	Bibliography	3
13	Miscellaneous	2

Three major limitations of the workshop were identified in question 23. There were 14 categories of limitations listed from a total of 144 responses. The three categories receiving the largest number of responses were time constraints, representation of participants and goals and objectives of the Workshop. Limited time was listed by 32 respondents. Representation of participants was indicated by 18 respondents. The third category, goals and objectives, received 13 responses. Responses to all categories of limitations are listed in Table 2.

Table 2: Ranking of Workshop I Limitations Based on Total Responses

Ranking	Strengths	Responses
1	Time	32
2	Representation	18
3	Goals and Objectives	13
4	Content	11
5	Moderator/Discussion Leaders	11
6	Consensus	10
7	Location/Accommodations	10
8	Participants	11
9	Proceedings	9
10	Discussion Groups	7
11	Nominal Process	6
12	Parliamentary Procedure	3
13	Publicity	2
14	Bibliography	1

Question 24 asked for other comments. There were 23 additional comments made. These responses were separated into 17 positive comments and six negative comments.

Discussion

The three speakers were identified as the most significant strength of the Workshop by 48% of the respondents. The speakers provided appropriate background and scope to support the Workshop goals which was verified in the four questions addressing this area.

Content was the second major strength listed by 42% of the respondents. The major thrust of the comments included the identification and discussion of relevant issues facing the future of dental hygiene and hygienists planning their own future.

Moderate satisfaction was achieved with the three major goals of the Workshop according to the responses. Although goals and objectives were identified as one of the three major limitations of the Workshop in Table 2, only 9% of the respondents made this response.

The nominal process was effective and allowed for interaction of participants in the general sessions and small discussion groups according to responses to the questions. The nominal process was also identified as a strength. Less than 10% of the respondents identified the process as a limitation. Respondents were also moderately satisfied with the moderator/discussion group leaders. The size of the discussion groups was also considered appropriate.

The overall organization of the Workshop was identified as the third strength by 31% of the respondents. In addition, respondents were moderately satisfied with the Workshop format as an effective means of arriving at consensus. There were 15% of the respondents that identified consensus as a limitation.

Time constraints were identified as the major limitation of the Workshop by 49% of the respondents. Limited time in small group discussions was the most significant comment made.

The second limitation identified was representation by 28% of the respondents. Respondents indicated that there was limited participation from either private practice, education or two year colleges. Representation was also identified as the fourth strength by 28% of respondents.

The location of the Workshop and the local arrangements were very satisfactory to respondents. In addition, hotel accommodations, registration procedures and fees, and arrangements for the reception, luncheon and breaks were very satisfactory.

The responses to question 24 which requested other comments were very positive. Some of the typical responses included:

Generally an exciting, informative, landmark meeting. I was glad

to be able to be a part of this and hopefully other such meetings.

After the workshop, I felt better about the future of dental hygiene than I had in many months.

I was pleased to participate in developing the future direction of the profession.

It was a pertinent, much needed meeting which provoked much thought and emotion about our future. I look forward to being challenged even more in the next workshop.

The ADHA must take leadership role in bringing out and encouraging discussion and debate on issues directly affecting the profession such as self-regulation and independent practice. Key issue is self-regulation to <u>any</u> kind of real growth and this issues must be out in the open.

There were six negative comments made. Four of the respondents expressed concern about scheduling the workshop after the Research Meeting. Two respondents identified the lack of an on-site evaluation.

SUMMARY

In some instances there is a clear and strong consensus on directions for the future, in others there is a divergence of opinion. Workshop I has begun the process and set the stage for Workshops II and III to continue to chart the course for the future of Dental Hygiene.

Education Workshop Agenda

Dental Hygiene Education Workshop I:
Focus on the Future of Dental Hygiene

Denver, Colorado

July 22 - 23, 1984

Schedule

Saturday July 21	3:00 p.m. - 6:00 p.m.	Registration
Sunday July 22	7:30 a.m. - 8:30 a.m.	Registration
	8:30 a.m.	Greetings: Cheryl Westphal, ADHA President GENERAL SESSION Introduction: Peg Ryan, Chairman, Workshop Steering Committee -Workshop Purpose and Goals -Workshop Process
	9:00 a.m.	Speaker: Felix Kaufman, B.Sc., D.I.C. "Societal Trends: Cultural, Economic, Demographic, Technical and Political"
	9:45 a.m.	DISCUSSION SESSION Societal Trends and the Future of Dental Hygiene -Identification of societal trends which will have significant influence on the future of Dental Hygiene
	10:45 a.m.	Break

11:00 a.m.	GENERAL SESSION Group Reports and Consensus Development: Societal Trends which have most significance for the Future of Dental Hygiene
12:00 p.m.	Lunch
1:30 p.m.	GENERAL SESSION Speaker: Barbara K. Kramer, Ph.D. "Trends and Issues: Health Care Policy, Health Care Delivery, and Treatment"
2:15 p.m.	DISCUSSION SESSION Health Care Delivery Treatment Trends and the Future of Dental Hygiene -Identification of Health Care Policy, Health Care Delivery and Treatment Trends: disease patterns which will have significant influence on the future of Dental Hygiene practice -Future roles for dental hygienists
3:30 p.m.	Break
3:45 p.m.	GENERAL SESSION

		-Health Care Delivery and Treatment Trends and disease patterns which will have the most significance for the future of Dental Hygiene practice
		-Future roles for dental hygienists
	5:00 p.m.	Adjourn
Monday July 23	9:00 a.m.	GENERAL SESSION
		Speaker: Carol Lindeman, RN, Ph.D.
		"Issues and Trends in Higher Education and Health Professions"
	9:45 a.m.	DISCUSSION SESSION
		Issues and trends in higher education and health professions and the future of Dental Hygiene
		-Identification of issues Dental Hygiene must address as an emerging profession
	10:30 a.m.	Break
	10:45 a.m.	-Identification of skills and goals for Dental Hygiene Education based on future roles of dental hygienists and the issues of an emerging profession

1:00 p.m.	GENERAL SESSION Group Reports and Consensus Development: Issues Dental Hygiene must address as an emerging profession; and philosophy and goals of Dental Hygiene education
2:30 p.m.	Summary and Projections for Education Workshop II
3:00 p.m.	Adjourn

GOALS FOR THE DENTAL HYGIENE WORKSHOP I

1. Develop consensus on the implications of relevant social, educational, political and professional factors for future Dental Hygiene Practice.

2. Forecast the future role of Dental Hygiene in health promotion and health care in the context of social, educational, political and professional factors.

3. Develop consensus on Dental Hygiene Education philosophy and goals in the context of the projected role of Dental Hygiene in health promotion and health care.

STEERING COMMITTEE OF EDUCATION WORKSHOP I

Brine, Pauline	Iowa
Dunham, Sara	Georgia
Hangorsky, Charlotte	Pennsylvania
Ryan, Peg	Oregon
Schmidt, Pauline	Ohio
Schwab, Cathy	California
West-Winship, Sally	Missouri

DENTAL HYGIENE EDUCATION WORKSHOP I

FACILITATORS

NAME	REPRESENTING
Giorgio, Suzanne	New Jersey
Hangorsky, Charlotte	Pennsylvania
Komives, Barbara	West Virginia
Lukken, Kathleen	Utah
McFall, Debbie	Colorado
Morr, Kathleen	North Carolina
Newman, Christine	New York
Smith, Marsha	Wisconsin
Zarkowski, Pam	Michigan

INSTITUTIONAL REPRESENTATIVES

PARTICIPANTS

Name	Affiliation
Abbott, Mary L.	Carroll College, MT
Alden, Betsey	Temple University, PA
Allen, Deanne	Old Dominion University, VA
Black, Cecelia	U.M.D.N.J., NJ
Byrne, Regina M.	Comm. College of Phila., PA
Carr, Elaine W.	St. Petersburg Jr. College, FL
Casey, Laurel B.	VA Commonwealth University
Biethman, Margaret B.	Johnson County Comm. Coll., KS
Christen, Karen A.	Phoenix College, AZ
Clifford, Susan B.	Pasadena City College, CA
Cross, Gail	University of Colorado
Edwards, Paul J.	University of New Mexico
Empey, Marge	University of Oregon
Enterman, Cindy J.	Southern Illinois University
Entwistle, Beverly	University of Colorado
Fales, Dr. M.H.	University of Washington
Fisher, Dr. Ijourie S.	Miami-Dade Comm. Coll., FL
Friedman, Dr. Leonard	New York City Tech. Coll.
Gaston, Mary Alice	University of Tennessee
Gentile, Linda	Pueblo Community College, CO
George, Wanda	Amarillo College, TX
Golightly, Sharon	Ft. Steilacoom Comm., WA
Grayden, Sharon K.	University of Minnesota
Hagan, Sharon Savage	Lane Comm. College, OR
Hartje, Judith	Eastern Washington State
Heine, Carole Sue	University of Colorado
Hoddy, Mary E.	North Central Tech. Inst., WI
Kannenberg, Karen	Loma Linda University, CA
Karras, Donna C.	University of Colorado
Laudenslager, Kimberly	University of Colorado
Goodwin, Ann	Fairleigh Dickinson Univ., NJ
Maloney, Karen L.	Northwestern University, IL
Malvitz, Dolores M.	University of Oklahoma
McCauley, Judith	State University of NY, Farmingdale
McComb, R. Lois	Sinclair Comm. College, OH
McNabb, Ann L.	University of Detroit, MI
Menschenfreund, Robin	Central Comm. College, NE
Mescher, Kay	University of Iowa

Name	Affiliations
Miller, Leslee	Oregon Institute of Technology
Murdock, Bonita S.	Macon Junior College, GA
Newell, Kathleen J.	University of Minnesota
Nichols, Sarah K.	Rose State College, OK
Noble, Janie Sue	Wharton County Jr. Coll., TX
Oldsen, Evelyn	Indiana Unviersity - Indianapolis
Palmateer, Trudy M.	Owens Technical College, OH
Patterson, Mark S.	Colorado Northwestern Comm.
Pattison, Anna	University of Southern California
Pohl, Donna	Milwaukee Area Technical Coll., W
Rigolizzo, Joann	Thomas Jefferson Univ., PA
Roman, Jocelyne D.	University of Bridgeport, CT
Rzasa, Lois J.	University of Colorado
Sauer, Susan	Loyola Univ., IL
Schnurr, Barbara J.	University of Louisville, KY
Steele, Pauline F.	University of Michigan
Tilliss, Terri S.	University of Colorado
Turner, Sarah A.	Hawkeye Inst. of Tech., IA
Tyrrell, Sally D.	Northern Arizona University
Wambach, Christine	Sheridan College, WY
Washnock, Sue	Old Dominion University, VA
Whitford, Lois T.	Mt. Hood Comm. College, OR
Wilson, Barbara L.	University of Rhode Island
Yoder, Karen S.	Indiana Univ./Purdue-Ft. Wayne
Yokom, Nanci G.	Indiana University - South Bend
Zimmer, Susan E.	Marquette University, WI

APPENDIX

Any ommissions or errors in the listing of participants is not intentional.

Please make the following correction in the bibilography listing:

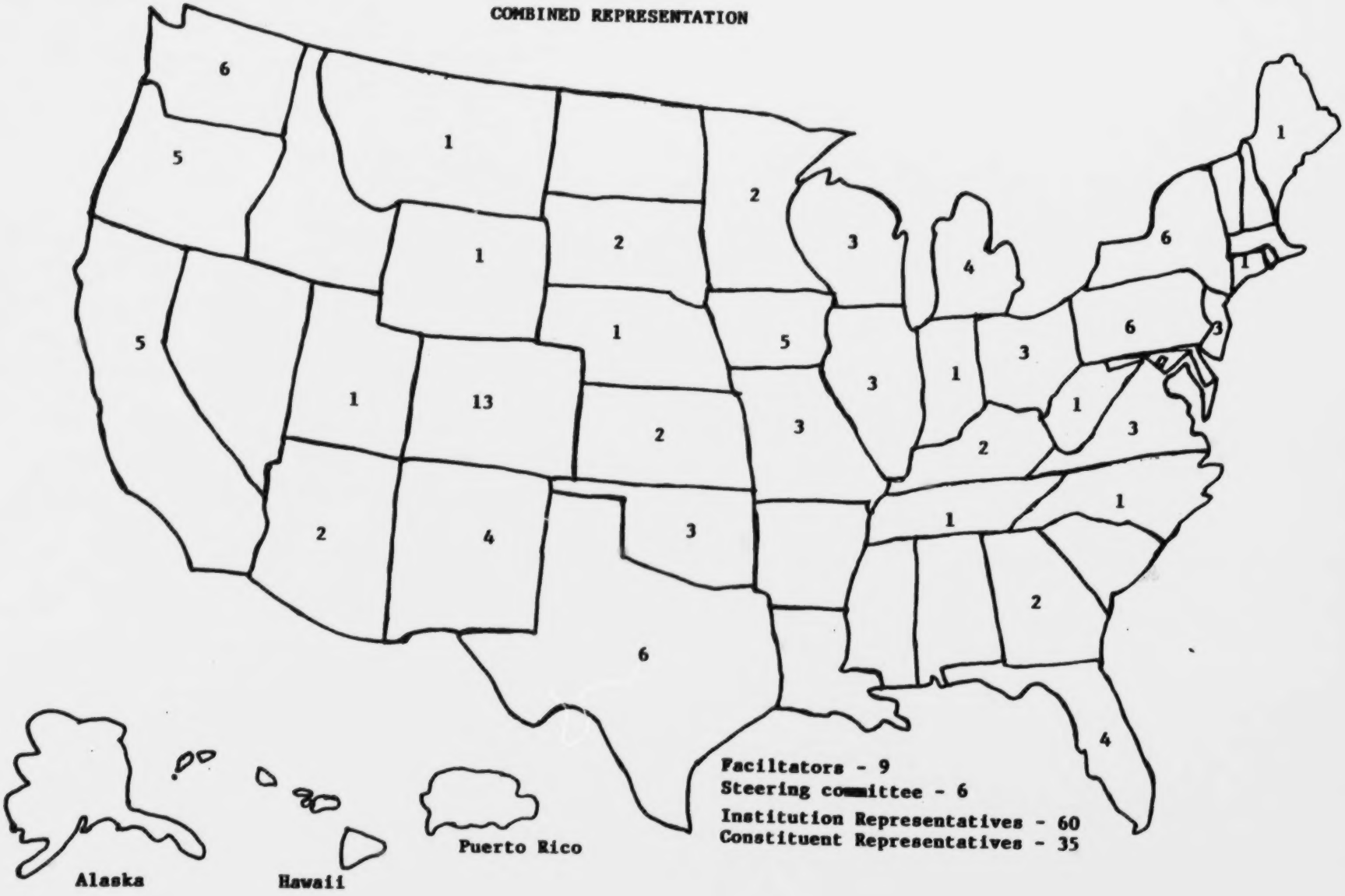
Kudrle, R. Dental Care. In National Health Insurance: Conference Goals and Policy Choices, pp. 567-609. Edited by Feder, Judith, Holahan, J. and Marnor, T. Washington, D.C.: The Urban Institute, 1980.

CONSTITUENT REPRESENTATIVES

PARTICIPANTS

Name	Affiliation
Baric, Jean M.	New York DHA
Bartelson, Mary Kay	Colorado DHA
Beatty, Chris	Texas DHA
Blankley, Cynthia	Colorado DHA
Brekke, Doris J.	Minnesota DHA
Cameron, Cheryl Ann	Washington State DHA
Deck, Sally	Michigan DHA
DeSpain, Becky	Oklahoma DHA
Dinius, Ann	Virginia DHA
Eberhart, Adele	Missouri DHA
Fallon, Pat	Texas DHA
Fatland, Robin Marie	Washington State DHA
Fritz, Shelly	New Mexico DHA
Froelich, Peggy A.	Ohio DHA
Girts, Karla J.	Oregon DHA
Hawkins, Margaret	Northern California DHA
Holmes, Robin Sue	Pennsylvania DHA
Holst, Patricia A.	South Dakota DHA
Huntley, Diane	Kansas DHA
Marrs, Helen	Colorado DHA
Miller, Susan	Maryland DHA
Munger, Maureen	Michigan DHA
Nielsen, Nancy Jean	Iowa DHA
Norton, Carolyn F.	Texas DHA
Parker, M. Elaine	Maryland DHA
Rodekohr, Valerie R.	Wyoming DHA
Shaffer, Clare L.	New York DHA
Skelton, Judy	Florida DHA
Spadafora, Agnes	Washington DHA
Tabor, Rebecca	Kentucky DHA
Taylor, Glenna	New Mexico DHA
Walsh, Peg	No. California DHA
Warren, Janet L.	New Mexico DHA
Wertz, Ann Rogers	Iowa DHA
Williamson, Barb	South Dakota DHA

COMBINED REPRESENTATION



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CONSTITUENT REPRESENTATIVES

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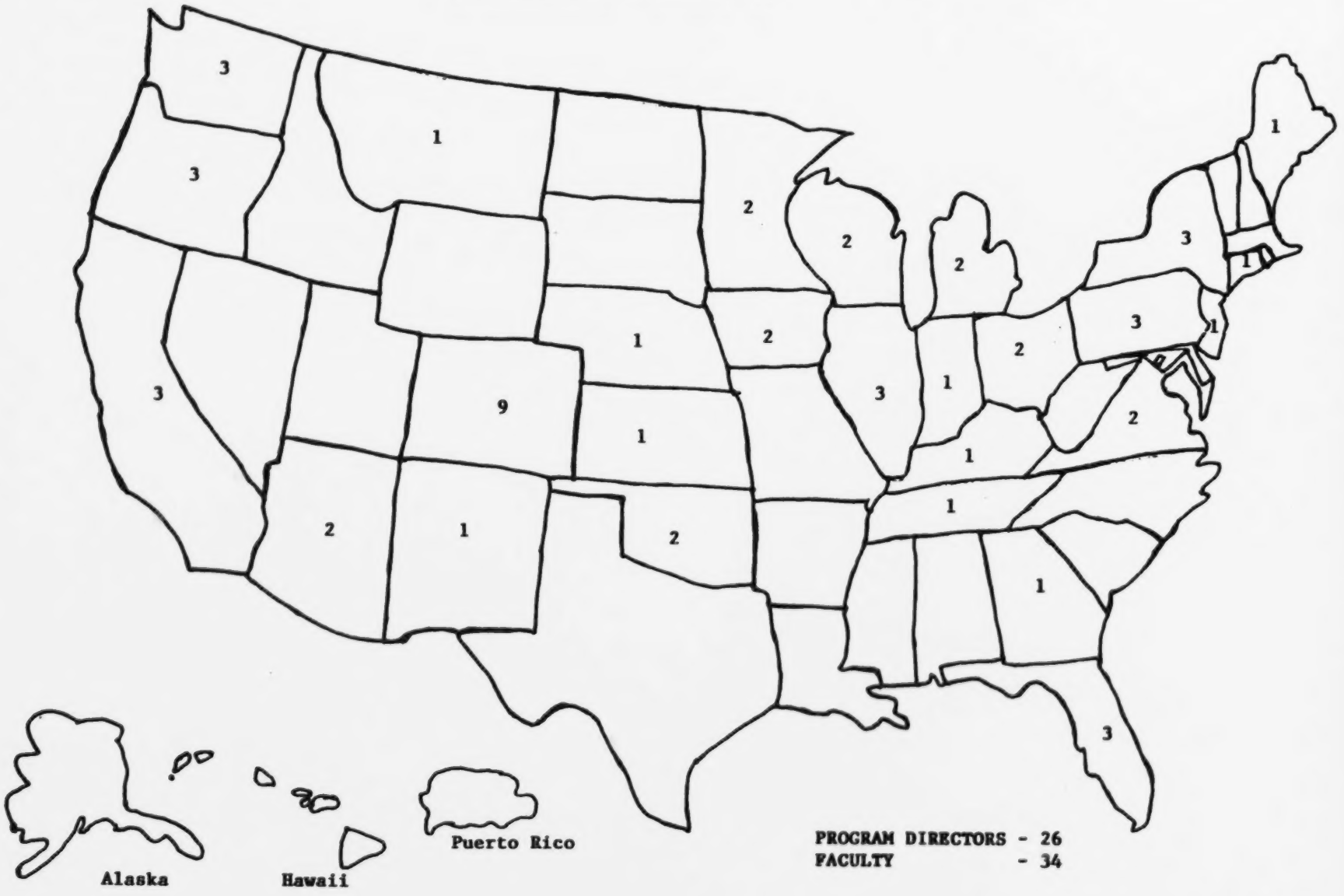
INSTITUTIONAL REPRESENTATIVES



PROGRAM DIRECTORS - 26
FACULTY - 34

(13)

NUMBER OF ACCREDITED DENTAL HYGIENE PROGRAMS IN UNITED STATES

(14)

Bibliography for National Dental Hygiene Education Workshop

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AMERICAN DENTAL HYGIENISTS' ASSOCIATION
DENTAL HYGIENE EDUCATION WORKSHOP: FOCUS ON THE FUTURE
DENVER, COLORADO
JULY 21-23, 1984

NOMINAL PROCESS

Introduction: The following process will be used for discussion sessions. The sequence of steps will be followed for each task or topic. For example, in the first discussion session scheduled at 9:45 on Sunday, each group will follow the steps in identifying the societal trends they believe will have the most significant influence on the future of Dental Hygiene. During the Sunday afternoon and Monday morning sessions, each group will go through the process twice, once for each of the two tasks assigned for each of those sessions. Before beginning, appoint a recorder or ask for a volunteer.

Steps:

1. Each person writes the ideas, issues, trends, roles (depending on the charge for the particular session) on 3 X 5 cards. Only one item is written on a card.

   Allow five (5) minutes for individual recording, without discussion.

2. Ask each person to identify one item using the nominal process, moving from one person to the next. Individuals should be allowed to "pass", if they wish.

   Recorder lists items on the tablet as they are presented and tapes sheets to the wall as they are filled.

   Once each member of the group has had an opportunity to offer an item, go around again. Repeat until all items have been presented.

   ITEMS ARE NOT DISCUSSED AS THEY ARE PRESENTED.

   Allow fifteen (15) minutes for this step.

3. Open discussion of the items. This is the opportunity for elaboration and explanation. Each person may ask questions about items, and/or defend or expand their items.

   Ask the group which items should be combined because they are the same or similar. Obtain consensus by voting.

4. Each person selects the three items s/he believes are the most important or significant on 3 X 5 cards (one item to a card). The entire statement is written.

5. Each person ranks the items according to importance, and writes the ranking number on the top of the card.

   3 = most important of the three
   2 = important of the three
   1 = least important of the three

6. Collect the cards.

   Allow five (5) minutes for steps 5 and 6.

7. Transfer the rank of each item from the cards to the master sheet. Example:

   Dental caries incidence is decreasing. 3,2,1,1,2,1,1 = 11

8. Determine the results of the group ranking by numbering the items. (The one which has the highest points is numbered 1, and the next highest, number 2, etc.)

9. Discuss the preliminary ranking completed in Step 8. Each person may explain their thinking and/or ask questions.

10. Repeat Step 8 if any members feel it is necessary as a result of the discussion during Step 9.

adha American Dental Hygienists' Association
444 North Michigan Avenue, Suite 3400
Chicago, Illinois 60611 (312)440-8900

Sara Dunham, RDH, President
Marjorie J. Sharpe, Executive Director

February 17, 1984

Dear Colleague:

The American Dental Hygiene Association is inviting one representative from each Constituent Dental Hygiene Association to participate in the National Dental Hygiene Education Workshop. In this, the first of three projected workshops, participants will:

1. Develop consensus on the implications of relevant social, educational, political and professional factors for future Dental Hygiene Practice.

2. Forecast the future role of Dental Hygiene in Health promotion and health care in the context of social, educational, political and professional factors.

3. Develop consensus on Dental Hygiene Education philosophy and goals in the context of the projected role of Dental Hygiene in health promotion and health care.

Attention will be focused on the future of Dental Hygiene in the context of society-at-large, rather than on education per se. As proposed, subsequent workshops will be designed to build consensus on the academic preparation of dental hygienists for practice in the future, and the educational structure required for that preparation.

The Workshop program will include keynote speakers from other fields who are recognized nationally for their vision, leadership and understanding of issues which relate to health care and health professions. The format will provide opportunity for free thinking, discussion and consensus building. Each dental hygiene education program has also been invited to send a representative.

The Workshop will be held on July 22 and 23, 1984 at the Fairmont Hotel in Denver, Colorado. A registration form is enclosed. Please note that the preregistration deadline is April 1, 1984 and the final deadline for registration is June 1, 1984.

We hope a dental hygiene representative from your constituent will attend the Workshop and participate in defining direction for dental hygiene.

Sincerely,

Sara Dunham RDH.

Sara Dunham, President

Enclosures
SD/mcm

(1972

adha American Dental Hygienists' Association
444 North Michigan Avenue, Suite 3400
Chicago, Illinois 60611 (312)440-8900

Sara Dunham, RDH, President
Marjorie J. Sharpe, Executive Director

February 17, 1984

Dear Colleague:

The American Dental Hygienists' Association is inviting one representative from each institution that offers a Dental Hygiene Program to participate in the National Dental Hygiene Education Workshop. In this, the first of three projected workshops, participants will:

1. Develop consensus on the implications of relevant social, educational, political and professional factors for future Dental Hygiene Practice.

2. Forecast the future role of Dental Hygiene in health promotion and health care in the context of social, educational, political and professional factors.

3. Develop consensus on Dental Hygiene Education philosophy and goals in the context of the projected role of Dental Hygiene in health promotion and health care.

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We hope a dental hygiene representative from your institution will attend the Workshop and participate in defining direction for dental hygiene.

Sincerely,

Sara Dunham RDH.

Sara Dunham, President

Enclosures
SD/mcm

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adha American Dental Hygienists' Association
444 North Michigan Avenue, Suite 3400
Chicago, Illinois 60611 (312)440-8900
Sara Dunham, RDH, President

Dear Colleague:

As a practicing clinical dental hygienist, I want to encourage your constituent representation at the upcoming ADHA Education Workshop I that will be held in Denver, July 22-23, 1984. The purpose of Workshop I is to develop consensus on issues facing the practice of dental hygiene in the future.

Health care delivery, disease trends, and the economy affect all of us in our day-to-day provision of care. When considering dental hygiene practice in the future, I know your constituent will want to be intimately involved in the deliberations of the participants at this important conference. Practicing dental hygienists need to contribute their perspectives.

Please plan to be there to take part in the future as it unfolds! Send your $25 registration fee in today so arrangements can be made for your representative.

Sincerely,

Cathy Schwab

Cathy Schwab, RDH

adha American Dental Hygienists' Association
444 North Michigan Avenue, Suite 3400
Chicago, Illinois 60611 (312)440-8900

Sara Durham, RDH, President
Marjorie J. Sharpe, Executive Director

Dear Program Director:

Please allow me to take this opportunity to encourage you to attend the National Dental Hygiene Workshop scheduled for July 22 and 23 in Denver, Colorado. An educator from each dental hygiene program and a practitioner from each constituent association have been invited for the purpose of joining together to address critical future-related questions. It is the first of three workshops planned to build consensus on the philosophy and goals of the dental hygiene profession. With the many societal changes that are occurring, there has never been a more critical time for us to come together and develop a unity of purpose.

I urge you to attend so that you may provide your very valuable input into these critical issues facing dental hygiene. I look forward to seeing you in Denver.

Very sincerely,

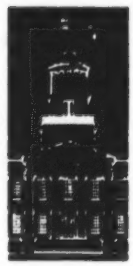
Pauline Schmidt

Pauline Schmidt, Chairman
Department of Dental Hygiene
Owens Technical College
Toledo, Ohio

The University of Iowa
Iowa City, Iowa 52242

College of Dentistry
Department of Dental Hygiene

(319) 353-5140



April 11, 1984

Dear Program Director:

I am writing this letter to urge you or a dental hygiene representative from your dental hygiene program to attend the National Dental Hygiene Education Workshop. As you know this workshop is to be held in Denver, Colorado on July 22 and 23 at the Fairmont Hotel for the purpose of joining with dental hygiene practitioners to examine critical issues that will influence dental hygiene practice in the 21st century.

It is critical that those of us who represent baccalaureate dental hygiene education attend this workshop, especially since baccalaureate programs constitute the smallest number, and this number is relatively static and may in fact be declining. Although it is important that our participation not be self-serving, it is important that we convey how essential baccalaureate level education is to developing professions and how necessary four-year colleges and universities are in planning for hygiene's future role in health promotion and health care.

I look forward to seeing you in Denver.

Sincerely,

Pauly Brine

PB:md

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Sara Dunham, President, ADHA

Educators Workshop

The Educators Workshop's Steering Committee met October 13 and 14 to prepare for the workshop series I introduced in the September issue of **Education Update**. Our planning for the 1984 workshop is well under way. Peering into the 21st Century is both frightening and exciting. The workshop series is sure to provide a stimulating forum for educators and practitioners to discuss the future of our profession.

The first workshop in this series will encourage dental hygiene educators and practitioners to work together to define the future characteristics of dental hygiene education and practice. As the bond between educators and practitioners is strengthened, education will become more unified resulting in firmly establishing the profession's role in meeting publics' needs for dental hygiene services.

The 1984 workshop will focus on trends in oral disease patterns, health care delivery systems and environmental factors that impact on dental hygiene. Inherent in these topics are educational considerations facing the campus today. Identifying the key issues which affect the future of dental hygiene will enable the profession to anticipate future practice based on anticipated public needs. Workshop speakers will discuss society at large, higher education and health care.

To establish tentative goals for the first workshop, the committee discussed the epidemiological outlook for oral disease and the present status of dental research. It is generally accepted that emphasis on restorative dentistry is declining and greater attention will be directed toward periodontal disease. Though periodontal care has been a central focus of dental hygienists, educators and practitioners alike must be prepared to place dental hygiene in a leadership position within this trend. The projected oral health care needs of the public and ensuring dental hygiene's dynamic role in the delivery of care were prime concerns of the Steering Committee.

Denver, Colorado has been chosen as the site for the first workshop. You will be receiving more information on the workshop through **Education Update** and correspondence to each school. I hope that you will make plans to participate in this event in July. Your valuable input will make a difference to the future of dental hygiene.

Reprinted from EDUCATION UPDATE, Newsletter of the American Dental Hygienists' Association, Volume 2, Number 4, 1983.

ADHA Educators' Workshops

The Mission Statement and Goals which the ADHA established this past year as part of our planning process are providing unified guidance to the Association. During the National Dental Hygiene Director's Conference in June, the directors expressed the need to establish national goals for dental hygiene education and practice. The establishment of goals for dental hygiene education can provide guidance and direction for the profession during the critical preparation stage of practitioners.

If steps are not taken to develop a national consensus, dental hygiene education will continue to move in diverse directions with resultant weakening of the educational structure. Now is the time for our profession to carefully examine the direction we are taking. The students you are teaching today will be practicing well into the 21st century. What you teach, how you teach and the emphasis your program places on the varying aspects of dental hygiene affect what our profession's future will be. Appropriate action must be taken promptly to avoid disintegration of the dental hygiene education system by evolution of disparate regional philosophies and goals.

The ADHA will conduct an educators' workshop series in response to the directors' appeal for the establishment of national goals. These workshops will provide an opportunity to insure a coordinated effort in defining the future characteristics of dental hygiene education and practice; and to establish consensus on preparation for dental hygiene practice in the year 2000.

The Workshop Goals will be:

- *Workshop I – 1984* – To formulate a common philosophy and goals for dental hygiene education in the context of projected public needs for dental hygiene services.
- *Workshop II – 1985* – To define the academic and clinical preparation required to reflect the philosophy and goals defined in the first workshop.
- *Workshop III – 1986* – To define the educational structure required to provide the academic and clinical preparation for practice in the year 2000; and to identify resources and strategies for attaining the ideal goals.

A special steering committee will plan specific objectives for each workshop. The committee will be chaired by Margaret Ryan and members will include Pauline Brine, Charlotte Hangorsky, Pauline Schmidt, Cathy Schwab, Sally West and myself. The committee will be meeting this fall to begin planning for the workshops.

It is essential that dental hygiene educators and practitioners work as a cohesive unit in defining the future characteristics of dental hygiene education and practice, and work together in attaining goals for the year 2000. The educators' workshops will provide the forum to accomplish a national consensus. We must look at the future of our profession together. The 21st century is less than twenty years away. Many things can and will happen in the next twenty years. We must be prepared for the upcoming changes and plan aggressively to meet them.

President's Message Reprinted from EDUCATION UPDATE, Newsletter of the American Dental Hygienists' Association, Volume 2, Number 3, 1983.

National Dental Hygiene Education Workshop

FOCUS ON THE FUTURE

Contributed by:
Margaret Ryan, RDH, MS
Chair, National Dental Hygiene Education Workshop Steering Committee

All dental hygienists, regardless of their field of professional endeavor, have a stake in the July, 1984, National Dental Hygiene Education Workshop. The agenda will not address education per se, but will focus on the future and the opportunities that social, economic and educational factors can provide if we use them constructively to promote health and provide health care. Attendees will include a representative from each Constituent and each Dental Hygiene education program.

Even a cursory look at what is occurring in dental hygiene practice and education raises concern about the future. Legally defined roles of dental hygienists vary considerably in scope and responsibility. To a significant degree, they reflect political and emotional views rather than logical evaluation of social and economic factors influencing health care needs and delivery. Practice opportunities and advancement have diminished. New restrictions are being placed on practitioners.

At times we have stepped forward only to back away when the risks became apparent. Widely divergent opinions on key issues have weakened our position. Whether you agree that these perceptions are accurate is not nearly as important as the fact that they are the perceptions of dental hygienists, legislators and other groups who have some control of our future. Without consensus on goals and priorities, and purposeful action, dental hygiene will continue to be buffeted by and vulnerable to the forces of society rather than essential to the advancement of society. Our actions have been considered reactive rather than proactive by many.

Three widely recognized speakers have been selected to offer insight on social, economic, educational and health care issues. Felix Kauffman, an international business consultant, will discuss social and economic factors which relate to the future of dental hygiene. Barbara B. Kramer, a health planning administrator, will speak on health care issues. Carol A. Lindeman, an educator and leader in nursing, will focus on higher education and professional education issues.

If Constituent societies and educational programs are willing to invest in the opportunity to creatively consider the future, dividends can be the ability to shape our future and be recognized as a significant force in health care.

Reprinted from HORIZONS, Newsletter of the American Dental Hygienists' Association, Volume 5, Number 3, 1984.

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AMERICAN DENTAL HYGIENISTS' ASSOCIATION
DENTAL HYGIENE EDUCATION WORKSHOP I
FOCUS ON THE FUTURE OF DENTAL HYGIENE
DENVER, COLORADO
JULY 22-23, 1984

EVALUATION QUESTIONNAIRE

PLEASE RESPOND TO THE FOLLOWING ITEMS IN TERMS OF THE EXTENT TO WHICH YOU BELIEVE THEY DESCRIBE THE EFFECTIVENESS OF THE WORKSHOP. CIRCLE THE APPROPRIATE RESPONSE. THANK YOU.

1 very satisfied 2 3 moderately satisfied 4 5 6 dissatisfied

	RESPONSES BY NUMERICAL VALUE											
	1	1-2	2	2-3	3	3-4	4	5	5-6	6	TR	M
1. To what extent was Workshop Goal Number One met? Goal One: Develop consensus on the implications of relevant social, educational, political and professional factors for future dental hygiene practice.	15	1	19	0	19	0	3	3	1	3	64	2.53
2. To what extent was Workshop Goal Number Two met? Goal Two: Forecast the future role of Dental Hygiene in health promotion and health care in the context of social, educational, political and professional factors.	7	1	19	0	19	0	10	4	1	3	64	2.92
3. To what extent was Workshop Goal Number Three met? Goal Three: Develop consensus on Dental Hygiene Education philosophy and goals in the context of the projected role of Dental Hygiene in health promotion and health care.	5	1	11	0	18	1	12	5	1	5	59	3.30
4. Did the speakers provide appropriate background and scope to support the goals?	14	1	8	0	5	0	2	0	0	0	33	1.82
a. Felix Kaufman	24	0	18	0	12	0	6	2	0	0	62	2.10
b. Barbara K. Kramer	20	0	17	0	15	0	6	2	0	0	60	2.17
c. Carol Lindeman	44	0	7	0	3	0	7	0	0	1	62	1.61
5. Did the bibliography provide an appropriate background for workshop goals?	17	1	17	0	13	0	5	3	0	0	56	2.26
6. Did the general sessions allow for interaction of the total group?	16	1	14	0	11	0	11	4	0	6	62	2.73
7. Was the nominal process effective in achieving workshop goals?	10	1	17	0	18	1	7	3	0	3	60	2.63
8. Did the discussion sessions allow for interaction of all participants?	24	1	19	0	6	0	7	4	0	2	63	2.21
9. Did the group discussion leaders facilitate discussion for all participants in their groups?	21	1	20	0	15	0	2	3	0	2	64	2.20
10. Was the size of the discussion groups appropriate?	24	1	22	0	6	0	5	3	0	2	63	2.16
11. Did the workshop format provide an effective means for arriving at consensus?	10	0	13	1	14	0	11	10	0	4	63	3.09
12. Was there appropriate time allocated for the general sessions?	7	0	16	1	13	0	11	8	0	6	63	3.12
13. Was there appropriate time allocated for the discussion sessions?	10	0	6	1	15	1	12	13	0	4	62	3.32
14. Was the location of the workshop reasonable for a national meeting?	23	0	23	1	7	1	1	4	0	2	62	2.10
15. Were the hotal accomodations suitable?	28	0	21	0	5	0	2	4	0	0	60	1.88
16. Did the meeting rooms support discussion groups?	27	0	25	0	7	0	2	2	0	0	63	1.84
17. Was the registration fee appropriate?	29	1	19	0	7	0	2	2	0	0	60	1.79
18. Were registration procedures efficient?	28	1	22	0	8	0	1	2	0	0	62	1.80
19. Were the reception arrangements appropriate?	28	1	19	0	3	1	2	0	0	3	57	1.81
20. Were the arrangements for breaks appropriate?	28	1	20	0	7	0	2	1	0	1	60	1.81
21. Were the luncheon arrangements appropriate?	28	1	25	0	4	0	1	1	0	1	61	1.66

22. List three strengths of the workshop.

a.

b.

c.

23. List three limitations of the workshop.

a.

b.

c.

24. Other comments:

APPENDIX

Any ommissions or errors in the listing of participants is not intentional.

Please make the following correction in the bibilography listing:

Kudrle, R. Dental Care. In National Health Insurance: Conference Goals and Policy Choices, pp. 567-609. Edited by Feder, Judith, Holahan, J. and Marnor, T. Washington, D.C.: The Urban Institute, 1980.